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myPRES Provider Portal Welcome Page

The myPRES Provider Portal home page contains a menu bar and quick links to reach other areas of the portal. We will review each area in the user guide.

Welcome to the Provider Portal

Introducing the Presbyterian ePayment Center

Presbyterian recently migrated to a new electronic payment platform called the Presbyterian ePayment Center. To accelerate payment and increase payment accuracy, contracted providers are encouraged to enroll in our new platform by visiting Presbyterian.epaymentcenter/registration. Should you require assistance in the enrollment process, please email Help@ePayment Center or call the Presbyterian ePayment Center Customer Service team at 1-855-774-4392.

Note: Behavioral health providers may disregard this notification. There will not be any changes to the electronic payment platform that behavioral providers use.

To view any previous communications regarding Presbyterian’s new electronic payment platform, please visit our News & Communications page located on the provider website at https://www.phs.org/providers/contact-us/news-and-communications.

UnitedHealthcare Centennial Care Members Will Transition to Presbyterian Health Plan, Inc.

Beginning Sept. 1, 2018, all current UnitedHealthcare (UHC) Centennial Care Members will transition to Presbyterian Health Plan, Inc. (PHP). Click Here to find out how this transition will affect your practice. Click Here to find out how this will affect our members.

Medicaid Enrollment Guidelines

As of February 1, 2018, the Centers for Medicare & Medicaid Services (CMS) require attending, ordering, referring, rendering and prescribing providers to enroll in New Mexico Medicaid. Click here to review the Medicaid enrollment guidelines.

Provider Tools

The toolbar along the right side of the screen contains quick link buttons that link to services where providers can look up a member’s eligibility information, check the status of a claim, request a claim adjustment, find the payment status of a claim and bring up a member roster that is applicable to the provider’s patient base.
Verify Eligibility

The Verify Eligibility quick link provides access to member eligibility information. The search requires entry of the member ID found on the member’s ID card or entry of the patient’s/member’s last name and date of birth. If a provider only has a patient’s/member’s last name or date of birth, a search can also be performed by using that information with a Group number. Providers may search for multiple member ID’s at the same time by entering a member ID, clicking the “Enter” button after each entry, then clicking on the “Search” button to activate the search.

After the search results screen appears, click on the member’s name to see the eligibility details. The data on the results screen can be sorted by clicking on the column headings.
Eligibility Detail contains access to the Network Directory where a provider search can be performed. The link for this service is located under the Provider Care Providers (PCPs) section. This same service can be accessed from the menu bar by choosing "Network Directory" service.

Within the “Eligible For” section, there is a link from the medical Plan Description where a provider can access summary information concerning the co-pays, coinsurance, out-of-pocket and plan limits of benefit plan under which an individual is covered. A Print View option is available if a copy of the summary must be kept on file.
Verify Claims

This quick link provides access to search for member claim information. The search requires entry of a member ID or a claim number. Providers can search for multiple claims at the same time by entering a claim number, then a comma before entering the next one. Click on the “Search” button to activate the search.

When the search results screen appears, click on the claim number to view details. The data on the results screen can also be sorted in this service by clicking on the column headings.
A print view option is available on the claim detail screen, if a copy of the claim must be kept on file (image below).
Claim Inquiry

This quick link provides access to request a claim adjustment form from the Provider Network Operations department, if the matter cannot be resolved through the myPRES Provider Portal, IVR, Healthcare Extranet or the Provider CARE Unit. An attachment option is available to use if the “Reason for Inquiry” or “Adjustment Request” on the form is more than 300 characters. If additional space is needed, it may be placed in a separate document and attached to the request before submission. This feature can also be used to submit any documentation applicable to the request.

When the request form opens, providers should complete the required fields and click on “Submit” at the bottom of the screen.

Provider Network Operations

Request Form Information:

Provider Network Management is here to assist you with inquiries and questions you may have about the myPRES provider portal or claims adjustments. If you have a claim adjustment question, please provide as much information as possible about the claim, including the claim number.

Please fill out the following form and click the submit button to complete your inquiry. A response will be sent to your “Messages” tab through myPRES.

All fields are required for us to process your request.

Please note that there is a 300-character limit. If you need additional space you may utilize the attachment feature by typing your question in a Word document and uploading it.

Submit
A confirmation message with a tracking number will appear online for the provider’s records.

### Payment Tracking

This quick link provides access to research claims payment details by claim number or check number. The search can be set to look for claims or check numbers applicable to all providers in the same practice or facility as well as those applicable to a specific provider of service within a practice or facility. To change the search from “All Providers” to a specific provider, use the “Select Provider” dropdown box to choose the provider ID number associated with that provider. If you are performing the search by claim number, then multiple claim numbers may be entered for the same search as long as the claim numbers are separated by a comma. Providers may also search by patient ID, date of birth or date range. Click on the “Search” button to activate the search.
The results of the search may be sorted by clicking on the column heading a user may wish to sort by. To view the claim detail, select the claim number in the results grid.

Member Roster

This quick link provides access to pull together a list of all members where the provider is assigned as the PCP or where one of the providers within a practice or facility is assigned as the member’s PCP. After selecting the provider, click on the “View All Patients” link. The other fields and the “Search” button can be used to do an eligibility search on a specific member, if desired. All data in the results of the member roster search is sortable. The results of the search may be sorted by clicking on the column heading a user may wish to sort by.

To search for individual patients, enter the patient’s Member ID, SSN, Medicaid ID or the patient’s last name and DOB.

If entering multiple ID Numbers, press the “Enter” key after each number.
Rosters can be exported into Microsoft Excel by clicking on the “Download Results” link (image below). To view details on a specific member’s eligibility, click on the member’s name.

The eligibility detail can be printed by clicking on the “Print View” link. To return to the member roster, click the “View All Patients” link next to the “Search” button.
Fast Claim

This quick link takes providers to a service where they can either enroll to participate in the online claims submission service or to log in to submit a claim online.

Menu Bar

Items on the menu bar provide access to additional services a provider might need.
Selecting Network Directory form the menu bar will take the provider to a provider network search service.
Authorization/Notification

When providers select “Authorization/Notification” for the menu bar, it will open two options that pertain to prior authorizations. Providers can choose, “Search existing authorizations requests” or “Submit a new authorization.”
In the “Search” portion of the screen, a provider may inquire about completed authorizations as well as submitted (pending) authorizations. Searches can be narrowed by authorization type (e.g., inpatient, outpatient, durable medical equipment), or date range. Providers may also search by authorization ID number or by member last name/date of birth.

The following actions are available to providers in the authorization submission service accessed from the right side of the screen:

- Inpatient, outpatient, or durable medical equipment prior authorization requests submissions
- Member lookup
- Auto-approval of some specific procedure codes, units, days and coverage
- Provider lookup within the request forms
- Procedure/diagnosis code lookup within the request forms
- Secure messages from Presbyterian to correct submitted requests and re-submit
- Editing rights for certain fields
- Ability to add attachments to authorization request forms

Each prior authorization type has a different submission service screen.

The “Select Member” button allows providers to choose the member for whom services are being requested. A sequence is a diagnosis code and procedure code set which combine with units to determine whether or not sequence and continue with the request. If the service cannot be auto-approved, the requesting provider will be presented with a checkbox to indicate agreement to move on.

When a provider begins to fill in the “Diagnosis Code” or “Procedure Code” fields, the service will assist in finding the applicable codes by pulling up a list of possible codes with descriptions from which the user can choose the appropriate codes/descriptions. Once selected, the input fields will be auto filled and the remaining Unit field must be completed by the provider before he/she can proceed.

After the “Add Sequence” button is clicked, the following screen appears if the service cannot be auto approved.

**Providers must check the box to proceed with the authorization request.**
Once the box is checked, additional fields will appear so the provider can include additional information in the request.

Medical, Rehab- Other, Surgical
Outpatient Services, Outpatient Surgery, Outpatient Rehab Therapy, Radiology Services

The “Select Provider” and “Select Facility” buttons will bring up a search screen with advanced search options.

If the “Next-Medical Criteria” button is selected before the member is selected, the provider will receive the following error: “A member needs to be selected”.
Additional fields will appear if “Yes” is answered to the “Accidental Information” or “Pregnancy Information” question. In that case, choose from the dropdown box provided to proceed to the next step.

### General Information

**Accident Information**
- Is Accident Related? (No, Yes)
- Accident Date: (mm/dd/yyyy)

**Pregnancy Information**
- Is Pregnancy Related? (No, Yes)
- Estimated Date of Birth: (mm/dd/yyyy)

### Medical Services

**Office, Outpatient Hospital, Ambulatory Surgical Center**

**Elective, Urgent, Emergency**

Additional fields on Medical Services section.

If the provider is not found through the Search Provider functionality, the user may add the provider to the request by clicking on the Add Provider link. When a provider is added rather than selected, the following screen will need to be completed.

### Provider Entry

If you were unable to find a provider please add a provider by entering the following required information.

- Name:
- Phone:
- (000-000-0000)
- Address:
- City:
- State:
- Zip:
- NPI:
- TIN:

Click “Save” to add the provider to your request.
The “Member Search Screen” is accessed by clicking on the “Select Member” button. This selection is a required step in the process since the search is designed to exclude members with termed eligibility.

Member ID, Medicare Number, Social Security Number

Sample member search results - click on the member’s name.

Sample member information which is the result of selecting the member’s name. This information is added to the authorization request by clicking on the Select Member button.
Selection of providers in this service is limited to those providers who have “PAR” (participating provider) status within the directory data.

Sample Search Results - Click on any underlined data in the results to select the provider.
Selection of facilities in this service is limited to those facilities who have “PAR” (participating provider) status within the directory data.

Sample Facility Results screen - Click on any result in the row to select the facility.
To move to the next step, click the Next - Medical Criteria button. If there are any errors or missing information on this page, error messages will display. Errors or omissions must be resolved before moving forward in the process.

Contact Name and Contact Phone Number are required.
Any desired attachments may now be added to the request. Once the request is completed, a summary screen will appear to confirm the information contained in the request. If all information is correct, the provider must click on “Submit Request.” If corrections are needed, click on the “Back” link to make necessary corrections.

### Outpatient Prior Authorization for

Effective for dates of service on or after October 15, 2014, all Commercial, Medicare, and A50 behavioral health prior authorization requests must be completed telephonically through Hudson Healthcare by calling 1-800-424-6035. If you have additional questions, please contact your Behavioral Health Provider Liaison or the Behavioral Health Provider Relations Department at 1-800-424-6035.

**Member ID:**

**Address:**

**Group ID:**

**Date of Birth:**

**Phone:**

### Service Details

- **Service Dates:**
- **Type of Care:**
- **Place of Service:**
- **Sequence 1**
  - **Diagnosis Code:**
  - **Procedure Code:**
  - **No. of Units:**

### Accident Information

Is Accident Related?

### Pregnancy Information

Is Pregnancy Related?

### Service Type

Medical

### Referral Type

Outpatient Services

### Physicians

**Authorization to:**

**Requested by:**

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**Address:**

**Phone:**

### Facility

**DR DAN C TRIGG MEMORIAL HOSPITAL**

**Address:**

**Phone:**

### Notes

**Contact Name:**

**Contact Phone Number:**

**Contact Fax Number:**

**Supporting Information:**

This screen is an opportunity to review the information entered on the previous form. If everything is correct, click “Submit Request.” To make corrections, use the “Back” link.
The screen below is returned when providers click the “Submit Request” button. The screen provides a tracking ID number for the Prior Authorization request.

### Outpatient Prior Authorization for

Effective for dates of service on or after October 15, 2014, all Commercial, Medicare, and ASO behavioral health prior authorization requests must be completed telephonically through Magellan Healthcare by calling 1-800-424-6957. If you have additional questions, please contact your Behavioral Health Provider Liaison or the Behavioral Health Provider Relations Department at 1-800-424-6957.

The following procedures require manual review to be approved:

#### Attach Supporting Criteria

Select a file to upload:

- [Choose File] No file chosen

*** From this point forward, only differences between the various types of services will be discussed. The search functions for member, provider, and facility will remain the same. The results columns may be slightly different from service to service, but functionality will remain the same.

### DME/OP Prior Authorization

On this type of request, facility and requesting type are not needed.

### Inpatient Authorization

For this type of request, units are not needed as they apply on to outpatient and DME service requests.

### Inpatient Admission

Different from the inpatient authorization request, the inpatient admission requests do not require completion of a medical services section, the servicing provider become the admitting provider and the servicing facility becomes the admitting facility.
Resource Links
The “Resource Links” form the menu bar will bring up the final list of services available to providers.

Provider Manual
The Provider Manual service contains essential information for providers and is an extension of the provider contract. It provides access to Presbyterian programs, policies and procedures for HMO, PPO, ASO, Indemnity, Presbyterian Senior Care, Presbyterian Dual Plus (HMO SNP), Medical PPO, and Presbyterian Centennial Care plans. Click the PDF icon link to open the manual.
The Provider Network Operations Contact Guide link opens a PDF document that contains contact information so providers can contact their Provider Network Operations relationship executive. The guide categorizes the various provider type service areas, and lists names, direct phone numbers, and email addresses for PNO staff.

Presbyterian’s Provider Network
Contact Guide

Your Guide to Presbyterian’s Provider Network Operations Department

+ Leadership
+ Long-term Care
+ Indian Health Services
+ Network Contracting
+ Behavioral Health
+ Physical Health

Contact Guide

Provider Network Operations
Contact Guide

Long-term Care Provider Network Operations

Managers and Supervisors

Crystal Gonzales
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Paulette Adakali
Manager
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padakali@phs.org

 Sammy Bailey
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Stacy Sullivan
Supervisor
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Relationship Executive
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sbailey@phs.org

Stacey Sullivan
Relationship Executive
(505) 923-6940
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Network Operations Contracting Team

SRS

Valerie helps develop and maintain provider relationships through personal and in-person discussions. She is responsible for developing and coordinating approval of new contracts, language and/or amendments using approved model contract templates and following health plan contracting procedures.

Lisa oversees the team responsible for conducting provider contracting functions including reimbursement negotiations, as necessary and to achieve cost targets and support network strategies. She also supervises and provides direction to team support development of contracts for acute inpatient facilities and integrated delivery systems, medical professionals and ancillary services, and specialist-purpose networks such as Medicare long-term-care/behavioral/dental.

Compliance Coordinator

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Network Contract Manager
(505) 923-5409
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Service Associate
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jruizmendoza@phs.org

Erica Lopez
Supervisor
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elopez5@phs.org
Formularies

The Formularies service displays the following screen where the provider can access pharmacy benefit information.

Formularies

The Presbyterian pharmacy benefit is an essential element in providing patients and members the medication they need while appropriately managing costs. Formularies include both brand name and generic medications that are commonly prescribed. Refer to our provider formularies to see if the drug you are prescribing is covered by the member’s plan.

Commercial Small and Large Group Plan Formularies

Information about prescription drug plans and a list of medications available to members in our small and large employer group plans who have prescription drug coverage provided by Presbyterian Health Plan.

Online Commercial Small Group and Large Group Plans (Non-Metal Plans) Formulary

- Commercial Small Group and Large Group Plans (Non-Metal Plans) – by Therapeutic Class
- Commercial Small Group and Large Group Plans (Non-Metal Plans) – Formulary Changes

Health Insurance Exchange Metal Level Plan Formularies

Information about prescription drug plans and a list of medications available to members on our individual and family plans or on a small employer group (1-50 employees) plans. (Applies to both on and off exchange plans.)

Online Individual and Family Metal Plans/Employer Group Metal Plans Formulary

- Individual and Family Metal Plans/Employer Group Metal Plans
- Individual and Family Metal Plan/Employer Group Metal Plans - Formulary Changes

Medicare Advantage Formularies and Formulary Updates

List of drugs approved by the Centers for Medicare and Medicaid Services (CMS) — that are covered by Presbyterian’s Medicare Advantage prescription drug plans.

Presbyterian Senior Care HMO/Medicare PPO

Centennial Care Formularies

Information about prescription drug plans and a list of medications available to members on our Centennial Care plan.

Online Centennial Care Formulary

- Centennial Care Formulary – Drugs by Therapeutic Class
- Centennial Care – Formulary Changes
- Drugs Requiring Prior Authorization for Centennial Care Plans

Supplement Formulary Information

- A list of drugs that have specific edits/requirements for coverage
- Specialty Pharmaceuticals/Medical Drugs List
- Formulary Addition Request Form
- Contraceptives Covered with No Co-Pay

U.S. Food and Drug Administration (FDA) Safety Alerts
U.S. Food and Drug Administration (FDA) Drug Recalls
Provider Communications
The Provider Communications service allows access to the Presbyterian Communications archive.

News & Communications

Network Connection Newsletter

Network Connection is our newsletter for contracted network providers and staff. It covers important information such as educational programs, policy changes and news about services.

Download latest issue

STAY CONNECTED

Would you like to receive network newsletters and email from Presbyterian? Please complete our opt-in form to register.

Sign Up Now

PAST ISSUES AND COMMUNICATIONS

This archive below hosts Presbyterian's provider network communications, organized by month of distribution. If you have any questions about a communication, or need to locate an older communication, please contact your Provider Network Management relationship executive.
Prior Authorizations

The Prior Authorization item on the service menu dropdown provides access to the Presbyterian Medical Policy Manual, Prior Authorization guide, printable Prior Authorization Request form, and instructions on how to fax authorizations to Presbyterian, general provider communications, preventive healthcare and clinical guidelines, specific disease material and miscellaneous forms.
When the Prior Authorization Guide service is selected, a PDF document that contains specific guidelines on different types of services is presented. Only a portion of the document is displayed below.

### Questions

Providers can submit questions and request for informations to Provider Network Operations. Please see the image below.

Click [here](#) to submit a Provider Network Management - Request For Information

To open the request form, click on the “here” link shown above. Complete the required fields to submit a request for information to the PNO department if the matter cannot be resolved through myPRES, IVR, Healthcare Extranet or the Provider Care Unit. An attachment option is available to use if the “Reason for Inquiry or Adjustment Request” on the form is more than 300 characters. If additional space is needed, it may be placed in a separate document and attached to the request before submission. This feature can also be used to submit any documentation applicable to the request.
When the request is complete, provider should click on “Submit” at the bottom of the screen to send the request. A confirmation message with a tracking number will appear online for the provider’s records.

A response to the request will be sent as soon as the matter has been researched. A notice will be sent to the provider user account of the individual making the request. The reply message can be accessed from the “Messages” link at the top of the website.

**Provider Network Operations**

**Request For Information**
Provider Network Management is here to assist your with inquiries and questions you may have about the myPRES provider portal or claims adjustments.

If you have a claim adjustment question, please provide as much information as possible about the claim, including the claim number.

Please fill out the following form and press the submit button to complete your inquiry. A response will be sent to your “Messages” tab through myPRES.

All fields are required for us to process your request.

- **Provider Name:**
- **Presbyterian Provider # or Tax ID #:**
- **Your ID Here**
- **National Provider Identifier Number (NPI):** *(Mandatory field as of January 1, 2007)*
- **Your NPI**
- **Provider Taxonomy Code:** *(Mandatory field as of January 1, 2007)*
- **Contact Name:**
- **Contact Phone:**
- **E-mail:**
- **Member Name:**
- **Presbyterian Member # or SS #:**
- **Presbyterian Claim # or Date of Service:**
- **Billed Amount:**
- **Is this a 2nd Request?**
- **select one**
- **Date of 1st Request:**
- **Reason for Inquiry or Adjustment Request:**

Please note that there is a 300 character limit. If you need additional space you may utilize the attachment feature by typing your question in a Word document and uploading it.

**Submit**
Providers may also add an attachment to the request for information prior to submitting the request.

**Add Attachment**

Allows providers to browse their computer’s file storage for supporting documentation.

(maximum file size: 10 MB)

Note: Uploading from certain mobile devices is not supported, i.e. iOS < 6 and older Android.

Description

Add

The remainder of the “Resource Links” tab includes this user guide, a link to FDA Drug News, web-based Centennial Care training, and the Provider Quality Incentive Program Gaps in Care reports.

Finally, the links on the provider footer section of each screen open documents which set out information on items such as contacting customer service, Presbyterian news, terms/conditions of website use and privacy.

***All member, provider and procedure pricing information used throughout this directory has been created for the purpose of training.***