THE Check-In

October 2025
communitycarehealth.org

COMMUNITY CARE HEALTH

Provider Newsletter

LETTER FROM THE CMO

Dear Colleagues,

Welcome to this edition of **The Check-In**, Community Care Health's provider newsletter. Our goal with this publication is straightforward: to keep you informed and supported as you care for our members. The healthcare environment is continually evolving, and timely, clear communication between our health plan and our network of providers is essential to delivering the best outcomes.

This issue covers several important updates and reminders that directly affect both your practice operations and our members' experiences. These include regulatory requirements such as the annual Provider Appointment Availability Survey (PAAS), Medical Record Audits, and new state legislation (AB 2843) waiving member cost-sharing for services related to sexual assault. Each of these initiatives reflects our shared commitment to compliance, accountability, and removing barriers to care.

We also highlight resources designed to streamline your daily work and enhance patient care, including our Provider Portal for real-time eligibility verification, clarity on timely access and referral standards, and updates on pharmacy prior authorizations. You'll also find information about support services such as no-cost language assistance, grievance resolution, and continuity of care benefits—critical tools to help you deliver equitable and coordinated care.

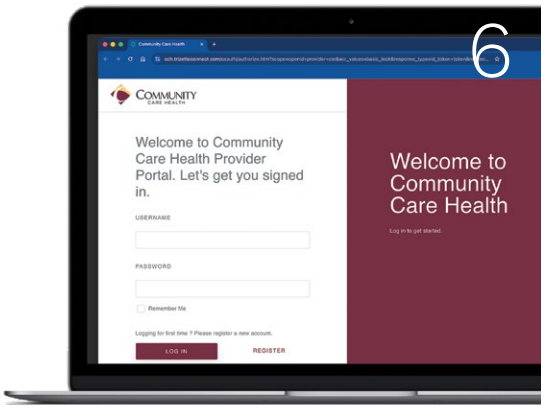
Most importantly, **The Check-In** is about partnership. By staying connected through these communications, we can ensure that our provider network remains aligned with best practices, regulatory expectations, and the needs of the patients we serve together. I encourage you to share this newsletter with your team, integrate these reminders into your workflows, and reach out to us whenever you need assistance or clarification.

Thank you for your ongoing dedication to excellence. Your expertise, compassion, and responsiveness make a real difference for every Community Care Health member. We are honored to support you in that mission.

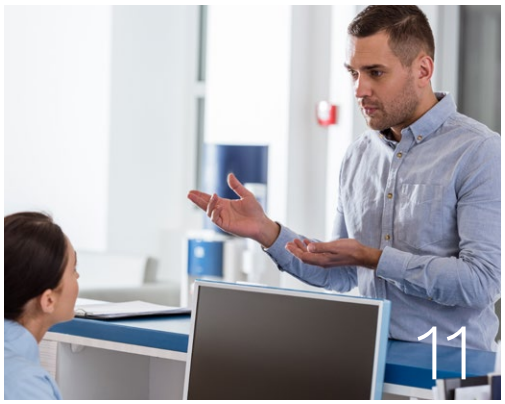
Sincerely,

Thomas Utecht, M.D.
Chief Medical Officer
Community Care Health

CONTENT



October 2025



The Check-In is brought to you from Community Care Health and is designed to keep providers abreast of the latest information in healthcare. We hope you find this a valuable resource.

COMMUNITY CARE HEALTH

Your Input Matters: Provider Appointment Availability Survey

In early September, Community Care Health, in partnership with QMetrics, began our annual Provider Appointment Availability Survey (PAAS). The survey is very short — just a few minutes to complete — and helps us meet state requirements while ensuring timely access to care for our members.

You should have already received the survey either by fax or through an online survey tool. Once received, please complete and return it as soon as possible. Responding promptly reduces the need for follow-up phone calls and keeps things easy for your front office staff.

We sincerely appreciate your time and participation. Your responses help us monitor appointment availability and support the highest level of care across our network.

Helps us meet state requirements while ensuring timely access to care for our members

Revolutionary Treatment Now Available to Central Valley Patients with Blood Cancer

A groundbreaking treatment shown to be curative in over 50% of patients with certain types of blood cancers is now available in the Central Valley thanks to specialists at Community Cancer Institute.

Dr. Haifaa Abdulhaq, Director of Cellular Therapy at Community Cancer Institute and Hematology at UCSF Fresno, and her team are the first to successfully deliver an immunotherapy called CAR-T cell therapy locally. Before, patients in the Valley had to travel to the Bay Area or southern California to receive the treatment.

CAR-T cell therapy, which was approved by the FDA in 2017, treats patients with advanced blood cancers such as non-Hodgkin lymphoma and multiple myeloma. Data from The National Cancer Institute shows that in CAR-T cell clinical trials involving those with large cell lymphoma, more than 30% had no signs of the disease after five years.

"CAR-T can cure about 50% of patients who otherwise do not have any other good options," said Dr. Abdulhaq.

T-cells are white blood cells that help the body fight infection and disease. CAR T-cell therapy extracts a patient's T-cells, which are then genetically engineered to produce special cancer-fighting proteins. Once they're infused back into the patient, these T-cells target and kill cancerous cells.

CAR-T cell therapy involves a lot of hardship and isolation — not just for the patient but for their caregivers, too. Having the therapy available locally makes it more accessible to those who are unable to put their lives on hold during treatment.

"Once you receive your infusion, you have to stay within two hours of your infusion center for 14 days with a caregiver that monitors you for 24 hours a day, seven days a week," said Erin Merrin, Cellular Therapy Program and Quality Manager. "So, it's not just you staying away from your home for days at a time, it's you and a loved one."

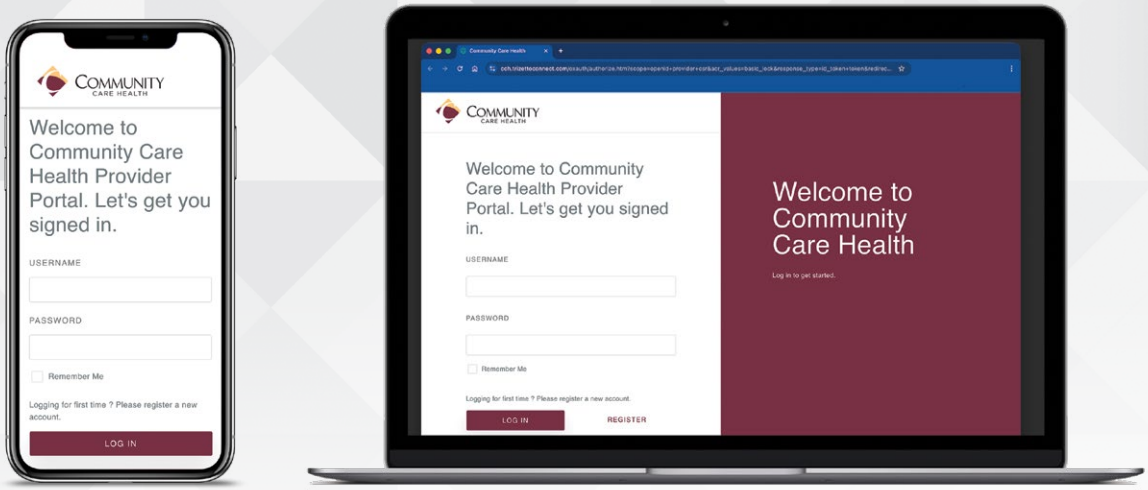
Two years ago, Christine Quintero was diagnosed with an aggressive form of lymphoma, a blood cancer that affects the body's immune system. The diagnosis came with limited treatment options.

"I just started thinking all these things like, 'I'm not going to make it. I'm going to, you know ... die,'" said Quintero.

Her oncology team at Community Cancer Institute suggested CAR-T cell therapy — the first patient in the Central Valley to receive the treatment. Two years later, Quintero's post-op scans show no signs of cancer in her body.

"We're hoping this is going to be the beginning of so many other patients that we can help," said Dr. Abdulhaq. "Because this is a revolutionary treatment. It is potentially curative for patients who otherwise do not have a cure."

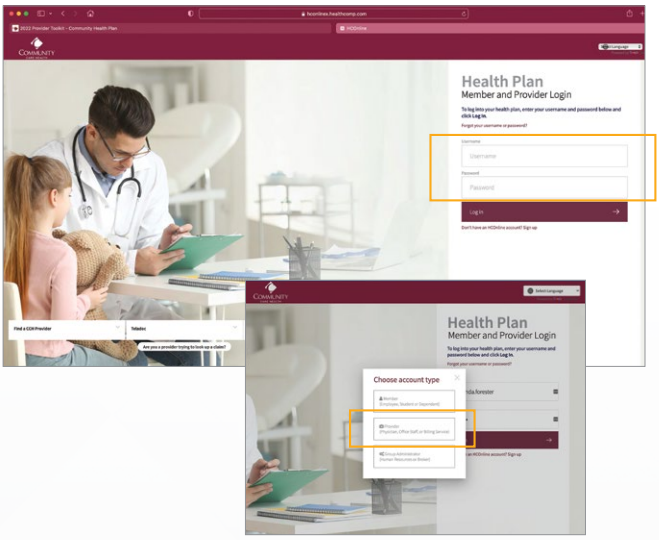
Spotlight: Provider Portal



Available to all providers in the Community Care Health network, the Provider Portal has been live since the beginning of the year and continues to be the quickest way to verify member eligibility — right when you need it.

WHY USE THE PORTAL

- **Instant eligibility verification** – confirm active coverage before an appointment or at check-in.
- **At-a-glance member details** – view plan information that helps your front office and billing teams work efficiently.
- **Fewer phone calls and delays** – get answers online and keep your schedule moving.



NOT REGISTERED YET?

Getting access is simple:

1. Email the Provider Relations team at providerrelations@communitycarehealth.org.
2. Include your practice name, TIN, contact name, and preferred work email.
3. You'll receive next-step instructions to complete your registration.

QUICK TIPS FOR SMOOTHER ELIGIBILITY CHECKS

- Search with multiple identifiers when available — member ID **and** date of birth improve match rates.
- Verify eligibility before every visit — benefits can change month to month.
- Save the Portal link in your EHR favorites or staff bookmarks to speed up access for front-desk teams.

The Portal was built to make your day easier — and eligibility verification faster. If you have questions about access or functionality, reach out to **Provider Relations** at **providerrelations@communitycarehealth.org**.

Burnett Extended Care Grand Opening: Skilled Nursing Care Center Opening Fall 2025

The newly redesigned and renovated 62,500 square-foot Burnett Extended Care Center will provide much-needed access to long-term and short-term skilled nursing care in Downtown Fresno. With 154 beds, the facility will not only provide skilled nursing care but also rehabilitative services to patients who are chronically ill or recuperating from an illness or surgery and will begin admitting patients this fall.

The Burnett Center has beautifully designed areas for patients and is equipped with the latestain therapy spaces and technologies that is expected to attract the best clinicians.

The facility is conveniently located downtown across the street from Community Regional, offering patients continuity of care and easy access to clinicians at the hospital. The two-story care facility features:

- Secure memory care unit with enhanced safety features
- Long-term care unit
- Rehabilitation unit
- Short-term care unit
- Two landscaped courtyards with serene environments

As the only skilled nursing facility in Fresno to have dedicated physical therapy and an occupational therapy gym onsite, the Burnett Center will provide high-quality, patient-centered care.

The occupational therapy gym has state-of-the-art equipment simulating a complete home-like environment (working kitchen, laundry, bathroom and a car) for comprehensive skill development in daily tasks that are crucial for our patients to achieve independence and a safe at-home experience post-discharge.

The physical therapy unit has the latest technologies, including Solo Step sling-assisted walking equipment that promotes faster recovery in gait, balance and strengthening.

“Having this so close to our downtown hospital not only provides necessary care and comfort for our patients but it allows them to be discharged safely to an appropriate care environment,” said Cory Belliston, Community’s Chief Operating Officer, Post-Acute Services. “There is a shortage across our region for post-acute care beds and this is a step to providing more access for those needing it.”

Medical Records Audit

Community Care Health strives to continually improve and monitor the quality of care and treatment rendered to our members by conducting periodic random medical record audits to measure provider compliance as set forth by the Department of Managed Healthcare. Contracted providers are required to provide health care services in a manner that provides continuity of care, including but not limited to the maintenance and ready availability of medical records, and the sharing with Community Care Health and other providers of all pertinent information relating to the health care of each enrollee.

Community Care Health's Quality Department conducts medical records audits to assess documentation practices by auditing medical records maintained by primary care providers to ensure the member's medical records are maintained in accordance with the standards set forth in the Community Care Health Provider Agreement and Provider Operations Manual.

Community Care Health Medical Records Audit:

1. Medical record audits are performed on primary care providers with at least 50 plan members or more
    a. A minimum of 10 medical records per provider will be selected and reviewed during their three-year re-credentialing cycle
        - Medical record audits are currently being performed only on providers with Epic access
        - Our intention is to include those providers who practice with other EMRs as well as those who use paper charting in the future
2. Medical records are randomly selected for audit
3. The provider, who is being audited, is notified in writing, prior to the audit
4. A standardized, generally accepted audit tool is used to complete the audit
5. The minimum passing score is 80%
6. Pass/fail audit results are furnished to the provider within 30 days after its completion
7. Providers who do not meet the minimum passing score will be referred to the Credentialing and Peer Review Committees as appropriate

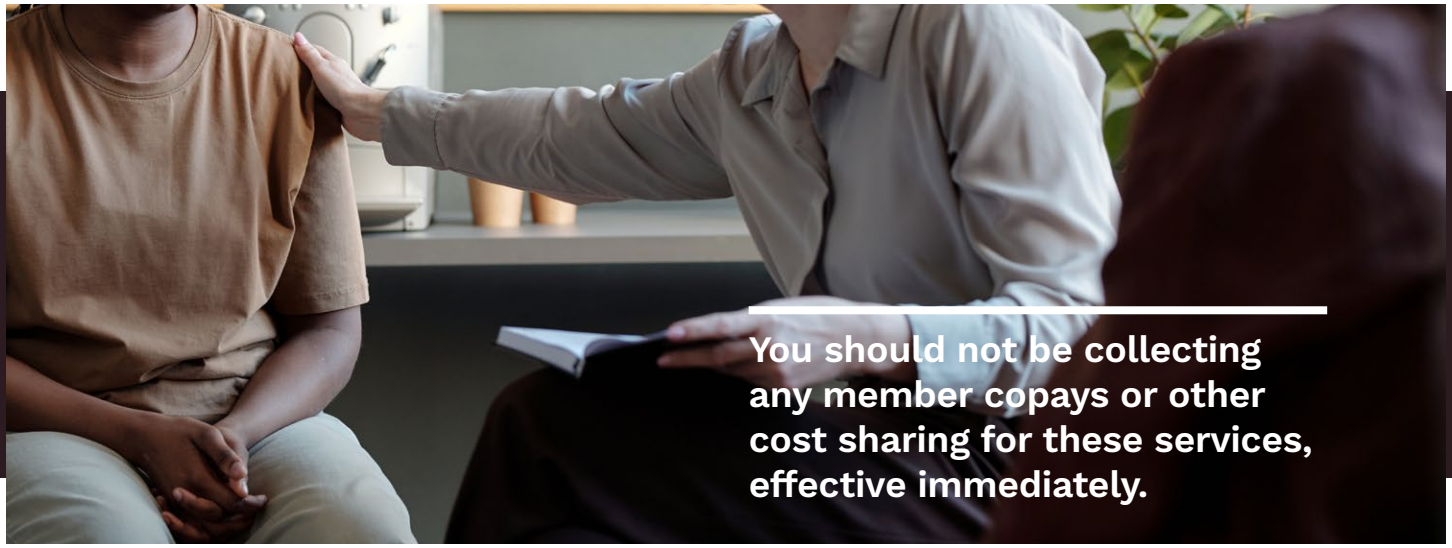
Results:

Community Care Health is pleased to report that we have performed 93 MRAs in 2025 to date with a 100% passing rate.

MRAs	Q1	Q2	Q3	Q4	TOTAL MRAs
2025	27	33	33		**93**

We thank you for you continued support and participation with our Quality Improvement Program initiatives!

AB2843: New California Law Requires Waiver of Cost-Sharing for Services Related to Sexual Assault



Effective July 1, 2025, health plans and insurers must waive all forms of member cost-sharing for emergency and follow-up healthcare treatment related to a sexual assault during the nine-month period following the assault. “Follow-up healthcare treatment” includes medical or surgical services for the diagnosis, prevention or treatment of medical conditions arising from sexual assault, including rape.

Community Care Health supports the legislature’s aim to remove financial barriers to care during that time. To demonstrate its commitment, Community Care Health will not limit the waiver to nine months and instead will waive member cost-sharing for these services regardless of when they are rendered.

This is important for you to know because you should not be collecting any member copays or other cost-sharing for these services, effective immediately. You should also not bill members for any amounts post-service. Be sure to use the appropriate diagnosis code on the claim form to indicate you are rendering care as the result of a sexual assault. We need that code so our claims system can correctly designate 100% of the allowed amount as the health plan’s responsibility, with no member copay or any other form of cost-sharing.

For physician offices, this means that even if you normally collect a copay for an office visit at the time of service, effective immediately the member will not owe a copay if the office visit is related to a sexual assault.

The same goes for hospitals and hospital-based physicians. Any copay or coinsurance that is normally owed for emergency or other hospital services is not owed for emergency room and follow-up health care treatment for members following a sexual assault.

If you are unsure if a member copay or other cost-sharing is owed for a particular service, or how much is owed, our Customer Service Department is available to help and can be reached at (559) 724-4995 or toll-free at 1 (844) 516-0181.

This new law and its cost-sharing waiver applies to rape or sexual assault, as defined in Sections 261, 261.6, 263, 263.1, 286, 287, and 288.7 of the California Penal Code. Please feel free to consult those sections of the law by clicking on the corresponding links.

If you have any questions about the new law, please call our Customer Service Department at (559) 724-4995 or toll free at 1 (844) 516-0181. We are here to support you!

No-Cost Language Assistance Services Available

Community Care Health offers a no-cost telephonic interpreter service to health plan members, both directly and through your offices, to provide language assistance to members with limited English proficiency. To get an interpreter, or to ask about written information in a non-English language for a member, please contact the health plan's Customer Services department by phone at (559) 724-4995.

Community Care Health members are all entitled to full and equal access to covered services, including members with disabilities, as required under the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. Customer Service representatives for Community Care Health are accessible by phone at (559) 724-4995, or toll free at (844) 516-0181, and are available to assist the speech and hearing impaired. Further, the speech – and hearing – impaired may use the California Relay Service's toll-free telephone number 1 (800) 735-2929 or 1 (888) 877-5378 (TTY).

Member Grievances and Potential Quality Issues (PQIs) Involving a Provider

An important feature of Community Care Health's Quality Management Program is the investigation and resolution of member grievances. A grievance is a member's expression of dissatisfaction with any aspect of their health plan, including their healthcare provider and/or the delivery of care.

Grievance forms and a description of the grievance procedure must be readily available at each contracting provider's office or facility. Both can be found on our website at the following link:

www.communitycarehealth.org/grievance-form

If a member grievance involves a provider, Community Care Health may need information from the provider to help resolve the grievance. In those cases, we will send a letter to the provider requesting the information and ask the provider to respond within seven (7) business days. If the grievance involves a provider, in many cases it also involves a potential quality issue (PQI). Our process for addressing PQIs is described below.

Potential Quality Issues (PQIs)

A PQI is a suspected deviation from expected provider performance, clinical quality of care, or outcome of care which requires further investigation to determine if an actual quality-of-care concern or opportunity for improvement exists. While PQIs are identified through multiple sources, many are raised through member grievances.

Upon receipt of a PQI, the Community Care Health Quality Department will send a letter to the provider containing a summary of the issue or allegation and ask the provider to respond within seven (7) business days. Medical records are requested if applicable to the member's issue. It is important for providers to respond promptly to such requests to ensure that grievances and PQIs are resolved within the timelines established by law.

When applicable, we use responses from providers to identify opportunities to educate members. The responses also highlight opportunities to work more closely with providers on interactions that are perceived to be problematic by members and to improve processes. Community Care Health views every grievance—PQIs and non-PQIs—as a chance to improve the member experience.

For additional information on Member Grievances and PQI policy, go to our website at www.communitycarehealth.org/grievance-process, scroll down to the bottom of the page to click on "attached document."

Community Care Health views every grievance, PQIs and non-PQIs, as a chance to improve the member experience.

Timely Access to Care

Medical and Mental Health Appointments and Timely Access to Care Health Plans in California must ensure that members have timely access to their physicians and other providers when seeking care. This means that there are limits on how long members have to wait to get an appointment and telephone triage or screening. The wait times are shown in the chart below. Some exceptions to the wait times apply. If you or a Community Care Health member are having difficulty in obtaining a timely referral to an appropriate provider, please call Customer Service at 1 (559) 724-4995 or toll-free at 1 (844) 516-0181. Providers and members can also file a complaint with the Department of Managed Health Care at www.HealthHelp.ca.gov or by calling 1 (888) 466-2219.

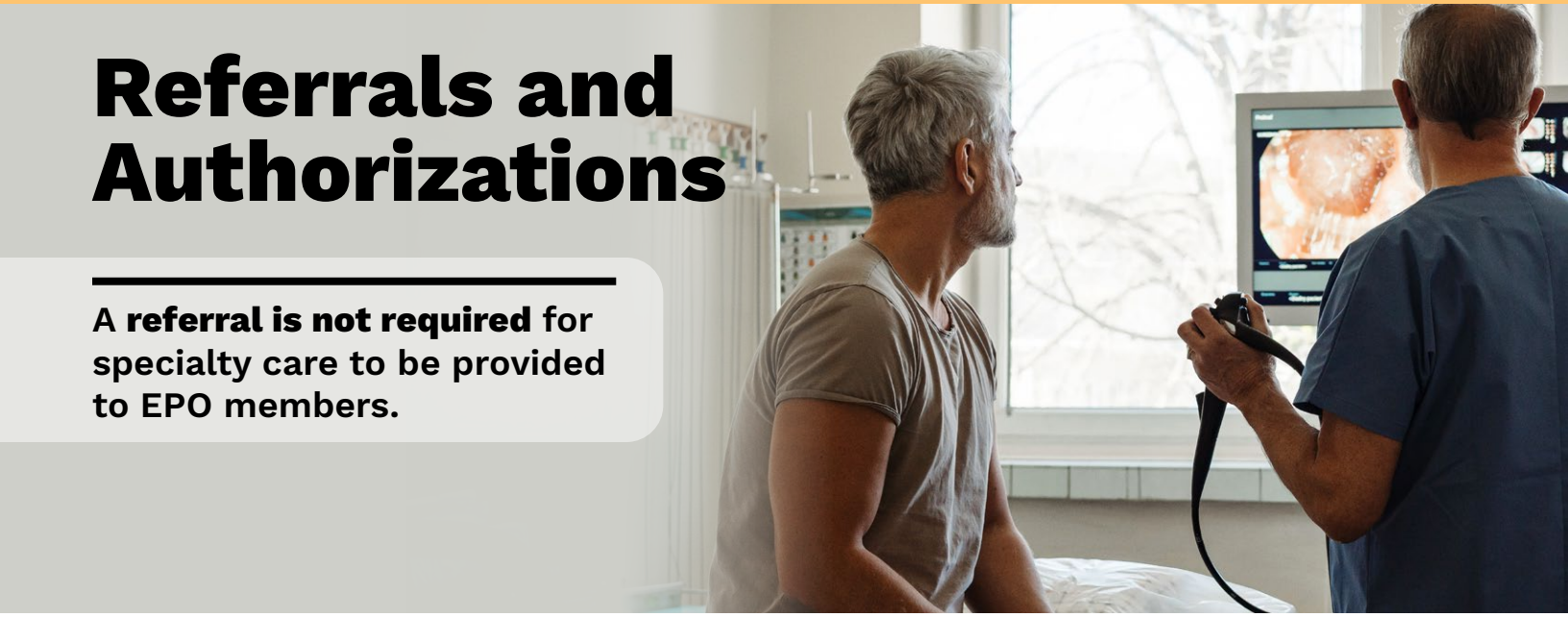
Appointment Type	Standard
Emergency care (life threatening)	Seek immediate care at the nearest hospital
Urgent care (non-life threatening) – no prior authorization required	Appointment is offered within 48 hours from time of the request
Urgent care (non-life threatening) – prior authorization required	Appointment is offered within 96 hours from time of the request
Non-urgent appointments with a primary care physician for regular and routine primary care services	Appointment is offered within 10 business days from time of the request
Non-urgent care appointments with a specialist	Appointment is offered within 15 business days from time of the request
Non-urgent appointment with a mental health provider (who is not a physician)	Appointment is offered within 10 business days from time of request
Non-urgent appointments for ancillary services for the diagnosis or treatment of an injury, illness or other heath condition	Appointment is offered within 15 business days from time of request
Telephone triage and advice	No greater than 30 minutes

BEHAVIORAL HEALTH EMERGENT & NON-EMERGENT APPOINTMENT ACCESS STANDARDS

Appointment Type	Standard
Non-urgent appointments with a physician mental health care provider	Must offer the appointment within 10 business days of request
Non-urgent care appointments with a non-physician mental health care provider	Must offer the appointment within 10 business days of request
Urgent care appointments	Must offer the appointment within 48 hours of request
Access to life-threatening emergency care	Immediately
Access to follow up care after hospitalization for mental illness	Must provide both: • One follow-up encounter with a mental health provider within 7 calendar days after discharge **Plus** • One follow-up encounter with a mental health provider within 30 calendar days after discharge

Other Regulatory Requirements:
After Hours Care: You should be able to reach a recorded message or live voice response providing emergency instructions and for non-emergent (urgent) matters information when to expect to receive a call back.
Emergency Care: Providers should instruct their after-hours answering service staff that if the caller is experiencing an emergency, the caller should be instructed to dial 911 or to go directly to the nearest emergency room. Answering machine instructions must also direct the member to call 911 or go the nearest emergency room if the caller is experiencing an emergency.

Referrals and Authorizations



A referral is not required for specialty care to be provided to EPO members.

Community Care Health offers both an HMO and EPO to both large and small group employers.

The main difference between an EPO and HMO is that only the HMO requires members select a Primary Care Physician and obtain a referral for specialty care. Please see below for a comparison of EPO to HMO.

Comparison of EPO to HMO	EPO	HMO
Primary Care Provider Selection Required		x
Referral Required for Specialty Care		x
Access to Full Community Care Health Network	x	x
Coverage Outside of the Area	x	x
All Emergency and Urgent Care Covered at In-Network Benefit Level	x	x
Access to Community Health System and Other Area Hospitals	x	x

REFERRALS

HMO

A referral from a member's primary care provider **is required** for all specialty services with the exception of allergy, most behavioral health and substance abuse providers (SimpleBehavioral), chiropractic, dermatology, and obstetrical and gynecological services. In addition, members can self-refer for emergency and urgent care. The primary care provider can initiate the referral via phone, email or by completing a referral form.

A copy of the Referral Form can be found on our website, www.communitycarehealth.org/for-providers. Any subsequent visits or additional specialized care, such as certain lab tests, imaging services or therapy, might require a new referral or prior authorization. In some cases, the member's condition will qualify for a standing referral to a specialist or specialty care center. Please note standing referrals require prior authorization from Community Care Health.

EPO

Selection of a primary care provider is not required for EPO members. A referral is not required for in-plan specialty care to be provided to EPO members. Members may call specialty providers directly to schedule their appointment. If you have questions about the service requested being a covered benefit, please contact Customer Service at 1 (559) 724-4995 or toll-free at 1 (844) 516-0181.

Pharmacy Coverage for Community Care Health Members

Community Care Health has partnered with MedImpact as our Pharmacy Benefit Manager to provide prescription drugs to our members. Community Care Health offers both retail and mail-order services. Members can obtain a 90-day supply of ongoing medications through the mail-order program with Birdi. To submit a prescription on behalf of a member please go to www.communitycarehealth.org/for-providers/#pharm and scroll down to complete a Birdi Enrollment/Medication Order Form and submit electronically via ePrescribing or fax to (855) 873-8739.

Community Care Health displays the Prescription Drug Formulary on our website. The formulary, which is updated monthly, provides a list of covered generic and brand name drugs selected by physician and pharmacist subject matter experts.

MedImpact has created a list of commonly prescribed medications, the Preferred Drug List (PDL) within select classes to promote clinically appropriate utilization of medications in a cost-effective manner. The PDL can also be found on our website.

Community Care Health and MedImpact have established a Formulary Exception Request Process to obtain non-preferred formulary drugs (Formulary Exception) for members. A physician must submit the request utilizing form 61-211, Prescription Drug Prior Authorization/Step Therapy Exception Request Form. The form is available on our website. Some covered drugs may have additional requirements or limits on coverage.

Pharmacy Coverage for Community Care Health Members

These are denoted throughout the Formulary listing using the following symbols (refer to table below).

Symbol	Guidelines	Description
AGE	Age Edit	For certain drugs, the plan limits coverage of the drug within a determined age limit.
PA	Prior Authorization	The plan requires enrollees or their prescribing providers to obtain prior authorization for certain drugs. This means that the enrollee will need to obtain approval before the prescription will be covered.
QL	Quantity Limit	For certain drugs, the plan limits the amount of drug that is covered.
ST	Step Therapy	In some cases, the plan requires a trial of certain clinically appropriate alternative drug(s) before obtaining the prescribed drug.
SP	Specialty Drug	Coverage may require dispensing from a specialty pharmacy. Specialty copay/coinsurance may apply depending on benefit. Prior authorization may be required.
DD	Diabetes Drugs/Devices	Drugs or devices used to treat or manage diabetes.
CT	Contraceptives	Drugs used to prevent pregnancy.
OCH	Oral Cancer Drugs	Drugs taken by mouth to treat cancer.

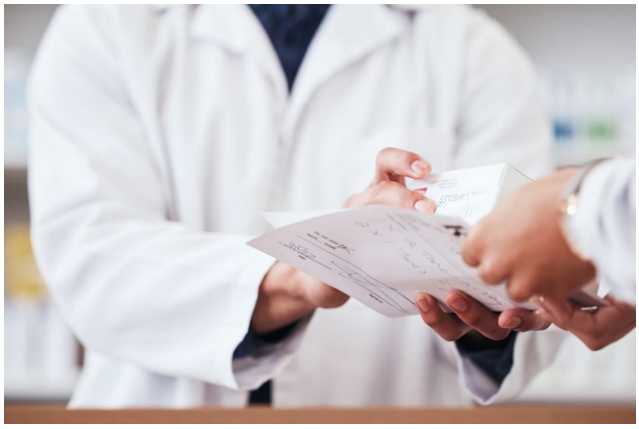
Failure to provide all required supporting documentation may result in the request being denied

Many drugs have multiple indications, so prior authorizations are placed on those drugs to make sure the drug is safe and appropriate for the member. Drugs that require prior authorization will show “PA” in the Coverage Requirements and Limits column of the Formulary document. Before these drugs are covered, the prescribing provider must show the member has a medically necessary need for the drug.

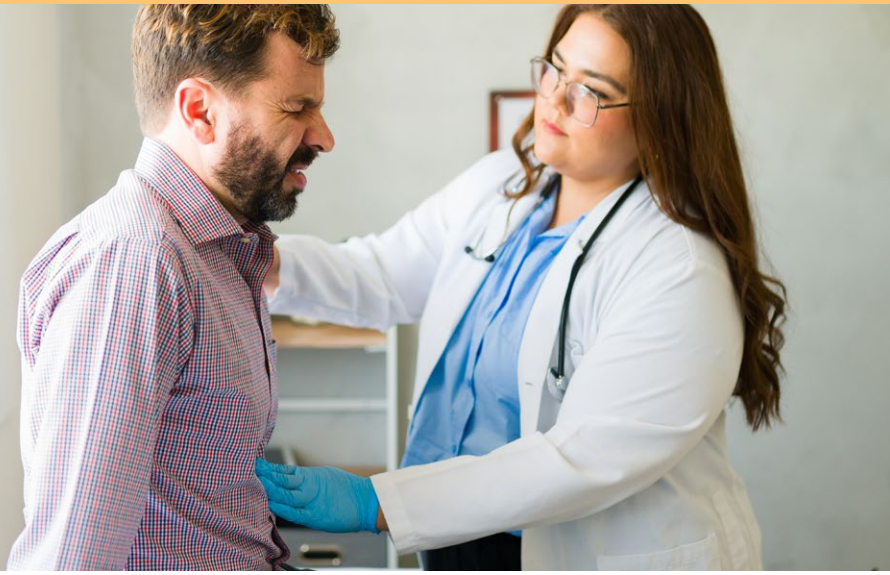
Drugs requiring prior authorization have specific clinical criteria the member must meet before the drug is covered. The prescribing provider should submit the form along with any supporting medical documentation to MedImpact by fax at **1 (858) 790-7100** or request by phone at 1 (800) 788-2949.

Upon receipt of all required supporting information, MedImpact will review the request and decide to approve or deny the request. **Failure to provide all required supporting documentation may result in the PA being denied.**

Decisions for routine requests are issued within 72 hours from the receipt of the complete information. If the member’s provider believes the member’s condition is life-threatening (exigent circumstance), the member’s request will be expedited, and a decision will be issued within 24 hours from the receipt of the information. If a decision is not reached within these timeframes, the member’s request is considered approved.



Continuity of Care



For new members or recently terminated providers.

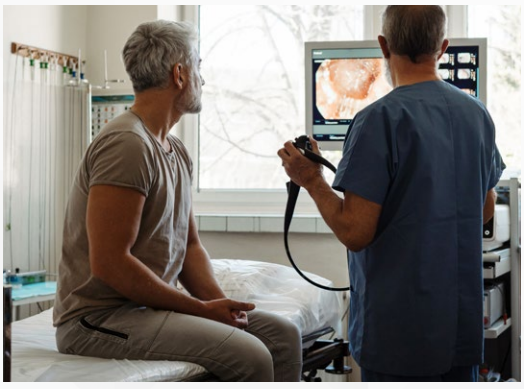
Enrolling in Community Care Health gives members access to a large network of participating doctors and other providers. A member may be undergoing treatment by a provider outside the Community Care Health network at the time of enrollment and may qualify for continuity of care (also known as COC). An existing member may also qualify for continuity of care if they are receiving care from a provider who leaves the Community Care Health network. This means the member may be able to finish the treatment or have a few more visits before fully transitioning to a participating provider within the Community Care Health network. This is called "Completion of Covered Services."

Please note: Continuity of care is for new enrollees and/or recently terminated providers—occurring within 30 days.

There are six conditions that may qualify for continuity of care:

An Acute Condition – A medical condition, including mental health, that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services will be provided for the duration of the acute condition.

A Serious Chronic Condition – A medical condition due to disease, illness or other medical or mental health problem or medical or mental health disorder that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services will be provided for the period of time necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a participating provider (a provider in the Community Care Health network), as determined by Community Care Health's Chief Medical Officer or his or her designee in consultation with the member, and either (i) the terminated provider or (ii) the non-participating provider and, as applicable, the receiving participating provider, consistent with good professional practice. Completion of Covered Services for this condition will not exceed 12 months from the provider's termination date or 12 months from the effective date of coverage for a newly enrolled member.



Continuity of Care

A Pregnancy – Diagnosed and documented by (i) the terminated provider prior to termination of the provider agreement, or (ii) by the non-participating provider prior to the newly enrolled member's effective date of coverage with Community Care Health. Completion of Covered Services will be provided for the duration of the pregnancy and the immediate postpartum period. In addition, for maternal mental health conditions diagnosed and documented by a terminating/non-participating provider, completion of covered services for the maternal health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

A Terminal Illness – An incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Services will be provided for the duration of the terminal illness, which may exceed 12 months from the provider contract termination date or 12 months from the effective date of coverage for a new enrollee.

Surgery or Other Procedure – Performance of a surgery or other procedure that has been authorized by Community Care Health or the member's assigned participating provider as part of a documented course of treatment and has been recommended and documented by the: (i) terminating provider to occur within 180 calendar days of the agreement's termination date, or (ii) nonparticipating provider to occur within 180 calendar days of the newly enrolled member's effective date of coverage with Community Care Health.

Care for Child who is a Newborn to 36 Months of Age – Care for a child who is a newborn to 36 months of age, not to exceed 12 months from the member's effective date of coverage with Community Care Health for newly enrolled members, or 12 months from the agreement termination date for members receiving services from terminated providers.

Request Continuity of Care Benefits

You can read our Continuity of Care Policy by visiting our website at https://www.communitycarehealth.org/continuity-of-care-benefits/ and scrolling down to Request Continuity of Care Benefits. You can also call us at 1 (844) 516-0181 if you have any questions. If the member has one of the conditions that may qualify for Continuity of Care, direct them to complete the Continuity of Care Request Form. The member can send the completed form to us by U.S. mail, fax or email:

U.S. Mail: Community Care Health
Attention: Continuity of Care Department
P.O. Box 45016
Fresno, CA 93718
Phone: 1 (559) 724-4995
Fax: 1 (559) 724-4750
Email: UM@communitycarehealth.org

Provider Resources & Contact Information

To support our ever-growing network of providers, Community Care Health has created a number of resources:

- **Quick Reference Guide – HMO**
- **Quick Reference Guide – EPO**
- **Provider Operations Manual**
- **Provider Referral Form – required for HMO Only**
- **Prior Authorization Form**
- **Prior Authorization List**
- **Quick Reference Guide – Pharmacy**
- **Provider Dispute Resolution Form**

To access these resources, please go to our website at https://www.communitycarehealth.org/provider-resources/

Our Provider Relations team is available to assist you with any questions. You can reach us at ProviderRelations@communitycarehealth.org.

Additional Resources:
Provider Portal: https://cch.trizettoconnect.com/tzf/provider/uiprovider/

Customer Service is available Monday - Friday from 8am - 5pm.
Phone numbers: (559) 724-4995 or toll-free at 1 (844) 516-0181