THE Check-In

September 2026
communitycarehealth.org



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COMMUNITY CARE HEALTH

Provider Newsletter

LETTER FROM THE CMO



Our Provider Check-In newsletter continues to serve as an important resource for keeping you informed, aligned, and supported as we navigate an increasingly complex healthcare environment together. In this issue, we highlight several important updates that may directly impact your practice operations, patient care delivery, compliance responsibilities, and member experience.

This edition includes an overview of new California laws affecting providers in 2026, including updates related to autism rediagnosis requirements, infertility services coverage, gender-affirming care protections, and continued coverage of mifepristone. We also share important reminders and guidance regarding timely access to care, referrals and prior authorizations, pharmacy coverage, provider directory accuracy, and contractual obligations associated with caring for Community Care Health members.

Additionally, this issue addresses member grievances and potential quality issues as well as resources available through medical and pharmacy assistance programs. Together, these topics reflect our ongoing commitment to supporting providers with clear communication, operational transparency, regulatory awareness, and tools that help improve both provider and member experiences.

At Community Care Health, we value the critical role our provider partners play in delivering high-quality, coordinated care throughout the Central Valley. Our goal is to foster strong collaboration, reduce administrative friction where possible, and ensure you have timely access to the information and resources needed to effectively care for our members.

Thank you for your continued partnership and dedication to the communities we collectively serve.

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

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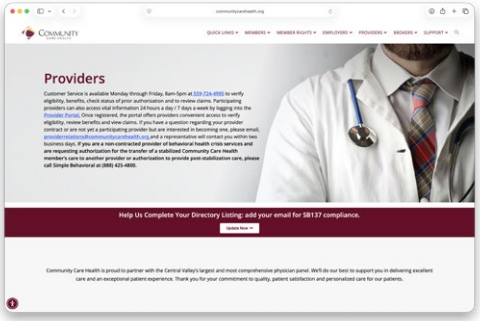
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The Check-In is brought to you by Community Care Health with the latest information in healthcare. We hope you find this a valuable resource.

COMMUNITY CARE HEALTH



California Laws Affecting Providers in 2026

Prohibition Against Requirement for Autism Rediagnosis

Effective January 1, 2026, Assembly Bill 951 prohibits health plans and insurers from requiring a member previously diagnosed with pervasive developmental disorder (PDD) or autism to receive a rediagnosis to maintain coverage for treatment of their condition. The bill's authors intended the law to relieve the burden imposed by some payers on families who were required to undergo a rediagnosis process that placed the child's continuing access to critical behavioral health treatment at risk.

This new requirement does not prohibit or restrict a treating provider from reevaluating a member for purposes of determining the appropriate treatment. Furthermore, it does not prohibit a treating provider from prescribing a rediagnosis at the discretion of a physician or psychologist. However, in both cases, existing treatment cannot be discontinued or delayed while waiting for a rediagnosis to be completed.



"Rediagnosis" is defined as a subsequent undertaking by any method, device, or procedure, whether gratuitous or not, to ascertain or establish if a person is suffering from a physical or mental health disorder. For purposes of this law, "rediagnosis" also means prescription of a subsequent diagnosis of PDD or autism to ascertain or establish if a person is suffering from PDD or autism.

Preventive Care Services and Federal Recommendations

Effective September 17, 2025, Assembly Bill 144 provides that California health plans and insurers will no longer follow the current federal recommendations for preventive care services. Instead, coverage will reflect the federal recommendations in effect on January 1, 2025, with input from the California Department of Public Health.

The new coverage requirement is as follows:

- Services that have a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF) in effect as of January 1, 2025, and as may be modified or supplemented by the California Department of Public Health.
- Immunizations for routine use in children, adolescents and adults as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) the American Academy of Pediatrics, and the U.S. Public Health Service in effect as of January 1, 2025, and as may be modified or supplemented by the California Department of Public Health.



Continuing Coverage of Mifepristone

Assembly Bill 260, which went into effect on September 26, 2025, requires California health plans and insurers to provide coverage for mifepristone, the medication used to end early pregnancies, even in the absence of FDA approval, under specified conditions.

The new coverage requirement is as follows:

Coverage is now required for brand-name or generic mifepristone, including certain products that may not be FDA-approved specifically for abortion, unless the state determines that limiting coverage is necessary to address an immediate health or safety concern.

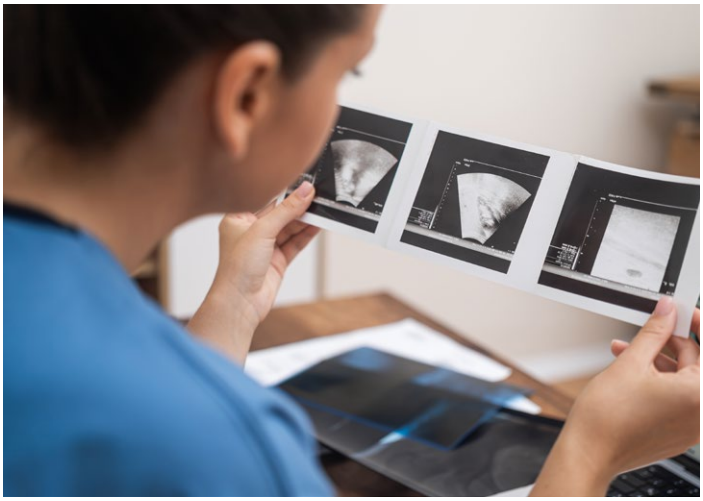
This requirement applies when either of the following conditions is met:

- The medication is recognized as an abortion treatment by leading medical authorities, such as the World Health Organization (WHO) or the National Academies of Sciences, Engineering, and Medicine.
- The state has approved its use based on peer-reviewed clinical evidence and prior regulatory approval, even if that approval is no longer in effect.
- Brand name or generic mifepristone, even if the drug has not been approved by the FDA for abortion, if the following requirements have been met, except if the state deems it necessary to address an imminent health or safety concern: (1) the drug is a recognized medication for abortion by the World Health Organization (WHO) Model List of Essential Medicines, the WHO abortion care guideline, or the National Academies of Science, Engineering, and Medicine Consensus Study Report, or (2) the state approves its use based on peer-reviewed studies and prior approval of the drug that is no longer in effect.



Coverage of Infertility Services

California Senate Bill 729 requires all new or renewed large employer group contracts in 2026 to cover infertility services. Similarly, all new or renewed small employer group contracts will cover infertility services if elected by the small group employer. The array of required services is quite broad and includes all of the following and more: collection or retrieval of sperm or oocytes, unlimited embryo transfers, invitro fertilization, surgery and medication to treat infertility, cryopreservation of genetic material, and donor and surrogate services. These services are subject to prior authorization by Community Care Health. For more information on infertility coverage, or to confirm if these benefits are available to your patient, call Customer Service at (844) 516-0181.



Medical Information Regarding Gender-Affirming Care

California Senate Bill 497 expands existing patient privacy protections related to gender-affirming health care and gender-affirming mental health care.

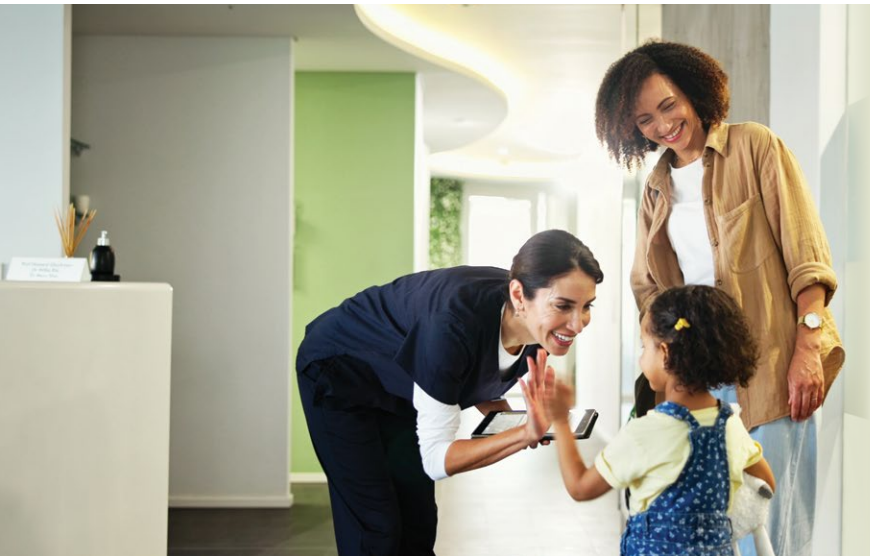
Under the law, providers and health plans generally may not release medical information in response to subpoenas or other requests that are based on laws from other states seeking to investigate, penalize, or interfere with a person's ability to seek, obtain, or provide gender-affirming care. These protections apply to both civil and criminal actions authorized under another state's laws.

Limited exceptions apply, including requests related to audits or investigations involving conduct that is considered a crime under California law.



The changes are reflected in California Civil Code Section 56.109. Providers and health plans should consult legal counsel for guidance regarding their specific obligations under Senate Bill 497.

Community Care Health Receives Interim NCQA Accreditation



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

Community Care Health Earns NCQA Accreditation
I am pleased to share that Community Care Health has earned Interim Accreditation from the National Committee for Quality Assurance (NCQA) for both our HMO and EPO plans.

NCQA is an independent, nonprofit organization that evaluates health plans against nationally recognized standards for quality, patient safety, care coordination, and operational performance. Achieving accreditation reflects the strength of our clinical programs, quality improvement efforts, and commitment to delivering high-quality care to the communities we serve.

This accomplishment would not have been possible without the dedication and partnership of our provider network. Every day, you help advance the quality measures, preventive care initiatives, care coordination efforts, and patient-centered practices that contribute to better health outcomes.

NCQA Accreditation validates many of the processes and programs we have built together, including:

- Promoting timely access to care
- Supporting coordinated care across providers, specialists, and care teams
- Using quality and performance data to improve outcomes
- Maintaining strong member protections and service standards
- Following evidence-based clinical guidelines and best practices

The accreditation process includes a comprehensive review of quality management programs, population health initiatives, utilization management, member experience, grievances and appeals processes, and ongoing performance improvement activities. Accreditation requires continuous evaluation and accountability and reflects a long-term commitment to excellence.

As Chief Medical Officer, I view this achievement as both a milestone and a responsibility. It recognizes the collaborative work of our providers, staff, and community partners while reinforcing our commitment to continuous improvement. Together, we will continue to expand access to high-quality, affordable care and improve the health of the individuals and families we serve throughout the Central Valley.

Thank you for your partnership and for the important role you play in helping us achieve this recognition. We look forward to building on this success together.

Supporting Maternal and Infant Health Equity



Community Care Health is committed to improving maternal and infant health outcomes through timely care, care coordination, provider partnership, and efforts to reduce disparities in care and outcomes.

Providers are required to screen pregnant and postpartum members for maternal mental health conditions using standardized, validated tools during pregnancy and the postpartum period. When concerns are identified, members should receive appropriate diagnosis, treatment, referral, follow-up, and emergency response when clinically indicated.

We also support member education and resource navigation related to pregnancy, postpartum care, behavioral health, social needs, and doula-related community resources. Doula services are not currently a covered Community Care Health benefit; however, members may receive appropriate information and referral assistance to community-based resources when appropriate.

Thank you for partnering with us to support equitable, high-quality care for mothers, infants, and families.

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: 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. Although our goal is to prevent situations that lead to member grievances, Community Care Health views every grievance—PQIs and non-PQIs—as a chance to improve the member experience.



Member Grievances and PQI Policy

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

We Need Your Help to Ensure Timely Access to Urgent Care



When a Community Care Health member reaches out to you with an urgent health issue, it is essential that you schedule them for care as quickly as possible. State law requires all health plans to ensure timely access to urgent care from their contracted providers.

For services that do not require prior authorization, appointments must be available within 48 hours of the patient's request.

The 48-hour timeframe is extended to 96 hours for services that require prior authorization from Community Care Health. However, it is important to note that most services involving urgent care needs—such as office visits—typically do not require prior authorization.

This is intended as a call to action. The Community Care Health network is currently falling short of meeting the state's urgent-care access standard. Last year's annual timely-access survey—used to assess next-available appointments—showed that barely half of our providers who answered the survey could offer an urgent care visit within the mandated timeframe. This does not meet regulatory expectations and, more importantly, fails to meet patient needs. Timely access to urgent care ensures patients receive prompt treatment for non-emergency illnesses and injuries, reducing unnecessary delays in care. It also helps ease overcrowding in emergency departments, enabling staff to concentrate on cases requiring immediate, life-saving intervention.

We need your partnership to improve access. When a member expresses an urgent need for care, please make every effort to accommodate them promptly. With your support in prioritizing urgent appointments, we expect to see significantly stronger results in this year's survey.

Finally, timely access requirements encompass other forms of care in addition to urgent care; the complete list appears on page 11. If you have any questions regarding timely access standards or your related contractual obligations, please contact ProviderRelations@communitycarehealth.org or call Customer Service at either 1 (559) 724-4995 or toll-free at 1 (844) 516-0181.

Timely Access to Care

Community Care Health is committed to ensuring members have timely access to medically necessary care in accordance with California regulatory requirements. As a participating provider, your practice plays an important role in meeting these access standards.

California regulations establish maximum wait times for appointments and telephone access services. Please review the chart below for the applicable standards and ensure your scheduling processes support compliance.

In certain circumstances, a longer wait time may be appropriate based on the member's clinical needs. When a provider determines that an extended wait time will not be detrimental to the member's health, that determination should be documented in the medical record.

We appreciate your partnership in providing timely, accessible care to our members. If you have questions regarding timely access requirements, please contact us at either 1 (559) 724-4995 or toll-free at 1 (844) 516-0181.

Medical and Behavioral Wait Times and Timely Access to Care

ACCESS TYPE	STANDARD
Access to non-urgent appointments with a primary care physician (PCP) for regular and routine primary care services	Appointment is offered within 10 business days from time of the request
Access to urgent care services with a PCP that do not require prior authorization – includes appointment with a physician, nurse practitioner or physician's assistant in office	Appointment is offered within 48 hours from time of the request
Access to after-hours care with a PCP	Ability for member to contact an on-call physician after hours; return call within 30 minutes PCP provides appropriate after-hours emergency instructions
Access to non-urgent care appointments with a specialist	Appointment is offered within 15 business days from time of the request
Access to urgent care services that require prior authorization with a specialist or other provider	Appointment is offered within 96 hours from time of the request
Telephone triage and screening	Provided within 30 minutes Available 24 hours per day, 7 days a week
Non-urgent appointments for ancillary services for the diagnosis or treatment of an injury, illness or other health condition	Appointment is offered within 15 business days from time of request
Non-urgent appointments with a mental health or substance use disorder provider (who is not a physician)	Appointment is offered within 10 business days from time of request
Non-urgent follow-up appointments with a non-physician mental health or substance use disorder provider for members undergoing a course of treatment for an ongoing mental health or substance use disorder condition	Appointment is offered within 10 business days of the prior appointment

Other Regulatory Requirements:

AFTER HOURS CARE	EMERGENCY 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.	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.

Medical and Pharmacy Assistance



Community Care Health Customer Service

Community Care Health Customer Service is available Monday through Friday, 8am-5pm at either 1 (559) 724-4995 or toll-free at 1 (844) 516-0181 to verify eligibility, benefits, check status of prior authorization and to review claims. Participating providers can also access vital information 24 hours a day / 7 days a week by logging into the Provider Portal at communitycarehealth.org > Quick Links. Once registered, the portal offers providers convenient access to verify eligibility, review benefits and view claims.

If you have a question regarding your provider contract or are not yet a participating provider but are interested in becoming one, please email, providerrelations@communitycarehealth.org and a representative will contact you within two business days.

Pharmacy Customer Service

MedImpact, Community Care Health's Pharmacy Benefit Management partner, has a dedicated customer service line for Community Care Health members and providers. They are available Monday through Friday, 8am-5pm at 1 (844) 348-8510. Participating providers can verify eligibility, obtain information on what is included in the formulary, check status of prior authorizations, and obtain the location of the nearest pharmacy.



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

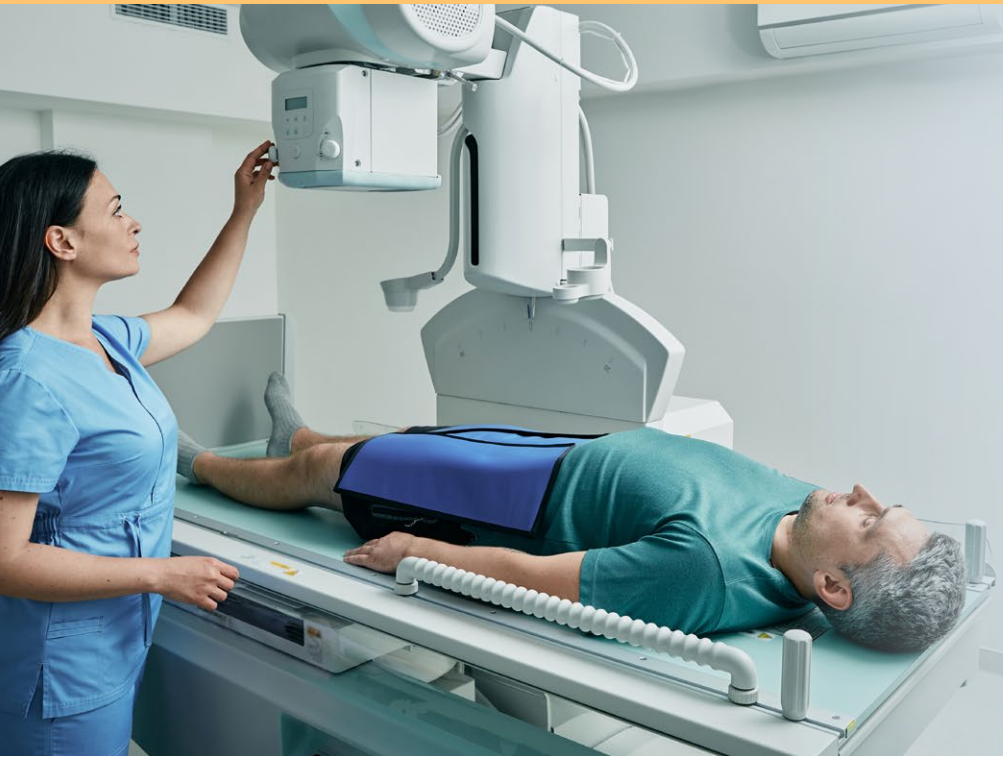
HMO

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 by visiting the Provider Resources section of our website (www.communitycarehealth.org/provider-resources/). 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.



Referring members to a non-participating provider, without Community Care Health's authorization, is in violation of your participating provider agreement.

Ensuring Members Do Not Incur Out-Of-Pocket Costs

Community Care Health has a wide array of providers serving our members and strives to minimize members' out-of-pocket costs.

Members may incur costs when they receive care from a non-participating provider, whether through self-referral or referral by a Community Care Health participating provider, or when a participating provider fails to obtain prior approval of a service that's on Community Care Health's prior authorization list. As a reminder, you can obtain a list of services requiring prior authorization by visitng the Community Care Health website or by calling Community Care Health Customer Service at 1 (559) 724-4995 or toll-free at 1 (844) 516-0181.

We want to remind you that referring members to a non-participating provider, without Community Care Health's authorization, is in violation of your participating provider agreement and may require Community Care Health to take corrective action up to and including termination. The member is likely to bring this to our attention by filing a grievance.

Laboratory services is the most common example where Community Care Health members are referred to a non-participating provider. Community Care Health's preferred laboratory provider is Quest Diagnostics and we request that providers only refer members to Quest Diagnostics. When members are directed to a non-participating laboratory such as LabCorp, the member may be required to pay out-of-pocket. If there is a service that Quest Diagnostics does not provide, such as genetic testing, we ask that you reach out to Community Care Health Customer Service at 1 (559) 724-4995 or toll-free at 1 (844) 516-0181 for assistance.



Prior Authorization Services List

Contractual Obligations to Treat Community Care Health Members



Community Care Health members who also have coverage under another benefit plan (including Medicare or Medi-Cal) are reporting in some instances they are being denied access to care. As a reminder of your contractual obligations under your Community Care Health Participating Provider Agreement, Section 3.1 Health Service states:

"In accordance with generally accepted community standards, Provider agrees to render appropriate and Medically Necessary Health Services to any Community Care Health Member who is covered under a Health Benefit Plan. This provision does not affect any right which Provider may otherwise have to elect not to provide treatment to any patient."

In addition, Section 3.4 Non-Discrimination states:

"Provider will treat Members and provide Covered Services on the same basis, in the same manner and with the same personnel that Provider uses with his/her non-member patients. Provider will provide Services to Members without discrimination on account of race, sex, sexual orientation, color, religion, national origin, age, physical or mental handicap, veteran's status or source of payment."

Should you have any questions or concerns, please reach out to Community Care Health Customer Service at 1 (559) 724-4995 or toll-free at 1 (844) 516-0181.

Reporting a Provider Directory Discrepancy



Accurate provider directory information helps members find and access the care they need. If you identify an error or need to update your practice or provider information, please use the Directory Discrepancy Report form available on our website.

Community Care Health may also periodically contact your office to verify directory information as part of our ongoing efforts to maintain accurate provider records.

Thank you for partnering with us to ensure our provider directory remains current and reliable for members, providers, and care teams.

Report a Discrepancy

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 visit the Community Care Health website and complete the Birdi Enrollment/ Medication Order Form.

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.

Birdi Enrollment/Medication Order Form



Pharmacy Coverage for Community Care Health Members

For certain drugs within the Formulary, a recommended prescribing guideline may apply. 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.

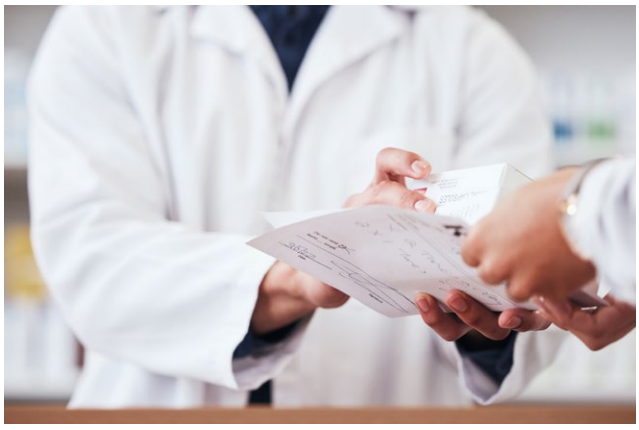
Failure to provide all required supporting documentation may result in the request being denied

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.

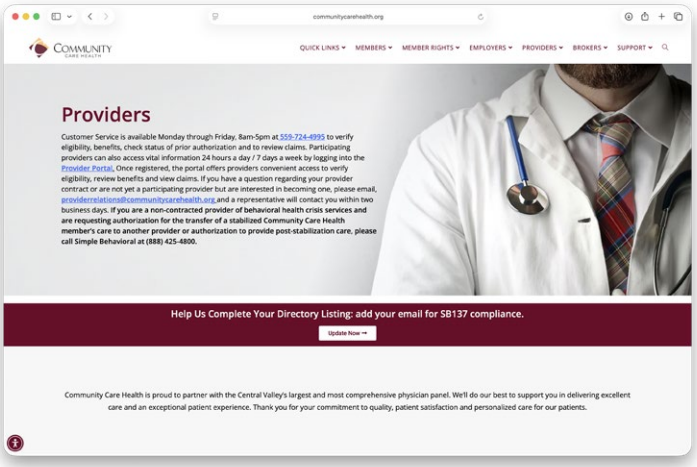
Drugs requiring prior authorization have specific clinical criteria the member must meet before the drug is covered. The prescribing provider should submit the form along with any supporting medical documentation to MedImpact by fax at **1 (858) 790-7100** or request by phone at 1 (800) 788-2949.

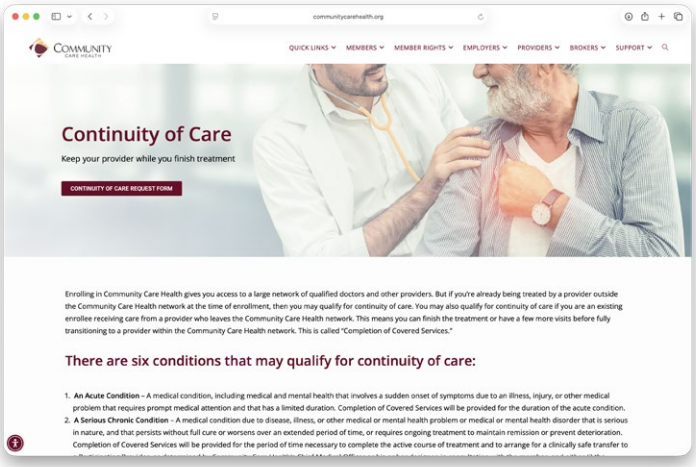
Upon receipt of all required supporting information, MedImpact will review the request and decide to approve or deny the request. **Failure to provide all required supporting documentation may result in the PA being denied.**

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.



Community Care Health Website





Provider Resources: Information When You Need It

The Community Care Health website includes a dedicated Providers section designed to give participating providers and office staff quick access to the information and resources they use most often. Whether you're looking for operational guidance, plan requirements, or commonly used forms, the Provider Resources area serves as a central hub for important tools and reference materials.

Within the Provider Resources section, you can access a variety of documents and resources, including:

- Provider Operations Manual
- Prior Authorization List
- HMO, EPO, and Pharmacy Quick Reference Guides
- Forms and administrative resources
- Policies and procedures
- Other provider-focused reference materials

These resources are regularly reviewed and updated to help ensure you have access to the most current information regarding Community Care Health products, processes, and requirements. We encourage providers and office staff to visit the site frequently and use it as a primary resource for day-to-day questions and operational support.

Our goal is to make it easier for providers to find the information they need so they can focus on delivering high-quality care to Community Care Health members.

As always, we welcome feedback from our provider community. If there are additional tools, documents, or resources that would help support your practice, please let us know. Your input helps us continue to improve the provider experience and enhance the resources available through our website.

Provider Resources

Claims Address



COMMUNITY CARE HEALTH

Providers contracted directly with Community Care Health should send claims for medical services to:

P.O. Box 45016
Fresno, CA 93718

Payer ID: CCH25

SimpleBehavioral

Claims for Behavioral Health Services should be sent to:

Electronically through:

OfficeAlly - Payor ID: HALCY
Fax: (855) 486-1341

Mail: SimpleBehavioral
ATTN: Claims
P.O. Box 25159
Fresno, CA 93729-5159

For behavioral health claims questions, please call SimpleBehavioral at: (855) 424-4457

SimpleMSK

Claims for Physical Medicine Services should be sent to:

Electronically through:

OfficeAlly - Payor ID: PM001
Fax: (855) 486-1343

Mail: SimpleMSK
ATTN: Claims
P.O. Box 25220
Fresno, CA 93729-5220

For physical medicine claims questions, please call SimpleMSK at: (877) 519-8839

Your Input Matters: Provider Appointment Availability Survey



In late 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



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Community Care Health
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Fresno, CA 93718

communitycarehealth.org

