

Published by First Health Services Corporation for the Alaska Department of Health & Social Services



First Health Services Corporation
A Coventry Health Care Company



February 2008

Alaska Medical Assistance Newsletter

Volume 3, Number 2

First Health Services Corp.
1835 S. Bragaw St., Suite 200
Anchorage, AK 99508-3469
<http://alaska.fhsc.com>

(800) 770-5650
(907) 644-6800

Useful FAX Numbers:

PA: 644-8131
PI/Enrollment: 644-8127
EPS: 644-8122
Finance: 644-8120
Attachments: 644-8122 or 644-8123

In This Issue:

NPI Required Effective February 13, 2008 1
J CODE NDC Requirement Extension.....2
Changes to Paper Medicare Crossover Claims2
Tips on Enhanced Dental Services for Adults3
Personal Care Assistant Regulations Change.....4
Revised UB-04 Claim Form Instructions.....5
How to Determine Your Type of Bill Code.....5
Field 57 on the UB-04 Institutional Billing Form6
What Providers Need to Know About PERM.....6
Why "Inactive Status" Occurs.....6
Correct Completion of the Certificate of Medical Necessity Form7
Crown and Denture Services Reminder.....7
Qualis Updates the Utilization Management/ Case Management Manual.....7
CMS Clarification of Provider Number Nomenclature7
Requesting a Fair Hearing8
Attention Prescribers and Pharmacies8
February Training for Providers.....9

First Health Services, in conjunction with the Department of Health & Social Services, publishes this monthly newsletter to offer providers useful information, monthly reminders, and tips on how to make billing easier.

NPI Required Effective February 13, 2008

Effective February 13, 2008, Alaska Medicaid requires the National Provider Identifier (NPI) number on all claims submitted electronically by covered entities (this includes 837I, 837D and 837P transactions). Alaska Medicaid requires the National Provider Identifier (NPI) number for the **billing provider** on all of these claims. In addition, Alaska Medicaid requires the NPI number of the **rendering/servicing provider** on any claim for which current billing standards require identification of the rendering provider. If you are unsure whether the rendering provider information is required on a specific type of claim, please refer to the billing instructions in your provider billing manuals.

Billers need to continue to send Medicaid provider identification numbers (also called legacy identifiers) in addition to the required NPI number(s). Alaska Medicaid will notify you when these legacy identifiers are no longer needed or permitted on electronic transactions. Refer to the companion guides at <https://alaska.fhsc.com/providers/hipaa/guide.asp> for instructions on where these identifiers are keyed on electronic transactions.

Please note that failure to supply the NPI results in claims denial on and after February 13, 2008. Providers should confirm with their electronic transaction vendors that NPI information is included on their file transmissions to Alaska Medicaid.

Electronic Claim Submitters:

837I, 837D and 837P claims must contain the NPI in the Billing Provider Loop 2010AA. In addition, for claims requiring identification of the rendering/servicing provider, see Rendering Provider Loop 2310 B. Required fields and values are as follows:

EDI 837 Field Name	EDI 837 Field Number	Values on Feb 13, 2008
Identification Code Qualifier	NM108	XX (Enter XX for NPI Qualifier)
Identification Code	NM109	10 digit NPI

Please direct any questions to the Provider Inquiry Call Center at (907) 644-6800 in Anchorage or outside the State of Alaska or at (800) 770-5650 from other locations in Alaska.

J CODE NDC Requirement Extension

For Drugs Administered in Outpatient Clinical Settings

CMS has granted Alaska Medical Assistance an extension to the deadline for changes to billing requirements for drugs administered in outpatient clinical settings. As a result, the new implementation date is now April 1, 2008. Please continue to work with your software vendors in preparation for this requirement.

Additional information regarding changes to the billing requirements for drugs administered in outpatient clinical settings can be obtained at <https://alaska.fhsc.com/providers/provupdates.asp> → **Notice of Changes to Billing Requirements for Drugs Administered in Outpatient Clinical Settings.**

Click [here](#) for a list of the HCPCS which will require a corresponding NDC. If you are unable to access this link to the FHSC Website, please contact FHSC's Provider Inquiry Unit at (907) 644-6800 or (800) 770-5650 (toll-free in Alaska) to request a hard copy.

A current listing of the manufacturers that have signed rebate agreements can be found on the CMS Website:

http://www.cms.hhs.gov/MedicaidDrugRebateProgram/10_DrugComContactInfo.asp .

UB-04 claim submission specifics can be found at <https://alaska.fhsc.com/providers/Billing.asp> → New UB-04 Claim Form Instructions, as well as at <http://www.nubc.org/>

CMS-1500 claim submission specifics can be found at <https://alaska.fhsc.com/providers/Billing.asp> → New CMS-1500 Claim Form Instructions - Set A, B, or C, as well as at <http://www.nucc.org/>.

For electronic claims, refer to <https://alaska.fhsc.com>, choose HIPAA -> Companion Guides.

Changes to Paper Medicare Crossover Claims

The paper Medicare crossover claims billing requirements will change effective March 19, 2008. At that time, Medicare crossover claims will be billed with the standard information required for non-crossover claims. Additional information will be required relating to the action Medicare has taken. This solution addresses both NPI and NDC requirements.

CMS-1500 Medicare Crossover Claims Instructions

Only one service per claim document is permitted. Use the claim billing instructions for a regular Medicaid claim. Values in the following fields are unique for crossover claims:

- Field 1: check both the Medicare and Medicaid box.
- Field 10D: (reserved for local use) enter the Medicare pay date.
- Field 11: enter the word "Medicare".
- Field 19: enter the deductible and coinsurance amounts using qualifiers A1 and A2 with a space between the qualifier and the amount (A1 100.00 A2 50.00).
- Field 24A, *shaded area*: enter the qualifier N4 and the 11 digits of the NDC code (no hyphens or spaces).
- Field 24D, *shaded area*: enter the NDC unit of measure (2 characters) and a total numeric quantity (9 digits) (99999.999). Be sure to enter the decimal point. Valid NDC unit of measurement codes are:
 - F2: International Unit
 - GR: Gram
 - ML: Milliliter
 - UN: Unit
- Field 24F, *shaded area*: enter the Medicare allowed amount.
- Field 24G, *shaded area*: enter "LTC" if the recipient is in a Long Term Care Facility (to exempt them from co-pay).
- Field 28, (total charge): enter the Medicare Billed Amount.
- Field 29, (amount paid): enter the Medicare Paid Amount.

UB-04 Medicare Crossover Claims Instructions

Use the claim billing instructions for a regular Medicaid claim. Values in the following fields are unique for crossover claims:

- Field 50: enter the word "Medicare". If Medicare is the primary payer, all information pertaining to Medicare will be on line A.
- Field 54: enter the Medicare Paid Amount.
 - If there is no secondary payer, line B will contain the Medicaid information.
 - If there is a secondary payer, this information will be on line B.
 - If there is more than 1 secondary payer, line B will be the sum of all the secondary payers.
- Line C will contain the Medicaid information.
- If Medicare is not the primary payer; the primary payer information will be on line A, Medicare information on line B, and Medicaid information on line C.

NOTE: A copy of the appropriate EOMB must be attached to each Medicare crossover claim.

For more information on completing the CMS-1500 and UB-04 forms, download the appropriate claim form instructions at: <https://alaska.fhsc.com/providers/Billing.asp>.

Sample crossover claim forms will be available soon on the FHSC Website. The availability will be announced in a RA message and in the March issue of the provider newsletter.

Tips on Enhanced Dental Services for Adults

Dental Providers: Please fax in your Prior Authorization (PA) requests for enhanced dental services for adults for faster and more efficient service. The fax number to use is (907) 644-9861. You will receive a faxed response for your record of what was approved, the effective dates of service, the provider ID number for which you requested the PA, and the Prior Authorization number so that you can enter all the correct information on your claims.

All Enhanced Adult Dental Services require a PA. PA requests must be submitted on the Medicaid Prior Authorization Request form. Claim forms are not accepted for prior authorization requests. Failure to provide the PA number on the claim will cause a delay in payment, and could cause the claim to be denied. Some other tips:

- Enter the approved Prior Authorization Number in Field #2 of the dental claim form.
- Enter the Alaska Medicaid Recipient ID Number in Field #15 of the dental claim form.
- If you are treating a recipient and need a prior authorization for an enhanced adult service, indicate the patient is in the office on the fax cover sheet and your response will be immediate.
- If you need to amend the PA, you can accomplish this by fax with the word "remove" next to the procedure that is no longer needed or the word "add" next to the procedures that you wish added.
- Faxed PA requests arriving before 8 a.m. will be credited for the previous day. For example, if you request a PA after hours on February 3 and it arrives before 8 a.m. on February 4, the effective date on the PA will be February 3.

Dentists may request a prior authorization by contacting First Health Services at (907) 644-5997 or (800) 994-7934. Prior authorization requests can also be faxed into First Health Services at (907) 644-9861.

It is recommended that you also fax in your requests for retroactive PAs for enhanced adult services. Reserve the use of the telephone to inquire about units and dollars remaining on a PA prior to faxing in your PA request. You can also use the telephone to inquire about recipient eligibility; call FHSC's Eligibility Verification System (EVS) at (800) 884-3223 (toll-free in Alaska).

Personal Care Assistant Regulations Change

The following is a summary of regulatory changes that have been filed regarding Personal Care Assistants. They became effective December 14, 2007.

- To be eligible for Personal Care Services, an individual's Personal Care Assessment Tool (PCAT) must show the need for:
 - Extensive help with at least one Activity of Daily Living (ADL), and
 - Limited help with at least one other ADL.
- If an individual is at increased risk to health and safety, the Department of Health and Social Services, Division of Senior and Disabilities Services (hereafter referred to as "the department") will consider expediting an assessment. This assessment will be for the determination of personal care services only, not for Home and Community-Based Waiver services. To request an expedited assessment:
 - Submit a request on a form and in the format provided by the department, and
 - Include medical documentation.

The PCAT and the *Request for the Expedited Assessment* can be found under Provider Resources: Assessment Forms on the Division of Senior and Disabilities Services Web page at <http://www.hss.state.ak.us/dsds/pca/default.htm> .

- A recipient who is eligible for chore services is not eligible for Instrumental Activities of Daily Living (IADL) services.
- The recipient may choose IADL services shown by the PCAT if:
 - The recipient is eligible for more 15-minute IADL services than are allowed under regulation as chore services, or
 - Chore services are not available within the community.
- The following jobs are no longer referenced as being specifically excluded from chore services:
 - Cleaning floors and furniture not used directly by the recipient,
 - Laundry not incidental to the recipient's care, and
 - Cutting firewood.

For a list of covered services, please visit the Division of Senior and Disabilities Services Web page at <http://www.hss.state.ak.us/dsds/pca/default.htm> . Under the heading Memos, Procedures, and Regulations, choose Personal Care Assistant Regulations (effective date: December 14, 2007), and refer to 7 AAC 43.752 (a).

- Approved services performed in the recipient's home are now covered for 30 days rather than two weeks per year while the recipient is away from the municipality of residence.
- Recipients cognitively unable to manage their own care may receive personal care services from an Agency-Based Program only. To remain under the Consumer-Directed Program, recipients must:
 - Obtain legal representation, or
 - Submit a form provided by the department and signed by a licensed medical provider stating that they are able to manage their own care.
- A "licensed medical provider" includes a tribal health care provider who is:
 - Employed by the federal government
 - Assigned to a tribal health care program or inter-tribal consortium, and
 - Licensed to practice in any jurisdiction in the United States or its possessions.

For more information, refer to the Division of Senior and Disabilities Services, Personal Care Assistant Program Web page at <http://www.hss.state.ak.us/dsds/pca/default.htm> .

Revised UB-04 Claim Form Instructions

The UB-04 claim form instructions have been revised to accommodate the billing requirements for drugs administered in outpatient clinical settings. Changes were made to the following field locators:

- 4 - Type of Bill
- 43 - Revenue Description
- 44 - HCPCS/Accommodation Rates
- 46 - Service Units

The revised UB-04 claim form instructions can be found on the First Health Services' Website at <http://alaska.fhsc.com/> → Providers → Updates → New UB-04 Claim Form Instructions or <http://alaska.fhsc.com/> → Providers → Billing Manuals → New UB-04 Claim Form Instructions.

To obtain a National Uniform Billing Committee Manual, call (312) 422-3390 or go to <http://www.nubc.org>. For more information regarding the need for these changes, refer to the *J Code NDC Requirements Extension* article in this newsletter.

How to Determine Your Type of Bill Code

When submitting institutional claims, please ensure that you are using the correct Type of Bill (TOB) code. This is a required field for all providers submitting institutional claims.

For providers submitting claims on the UB-04 claim form, the TOB code must be entered in Field Locator 4.

The TOB code consists of four digits and indicates the specific type of facility, bill classification and frequency of the bill being submitted.

- 1st digit: A leading zero (PayerPath billers do not need to key the leading "0"; PayerPath will appropriately format for HIPAA-compliant transmission.)
- 2nd digit: Type of facility, e.g., 1=hospital, 2=SNF, 6=ICF.
- 3rd digit: Bill classification, e.g., 1= inpatient, 5=ICF, 8=hospital swing or administrative wait bed.
- 4th digit: Defines the frequency of the bill for the institutional claim, e.g., 1=admit thru discharge claim, 2=interim billing, first claim, 3=interim billing, continuing claim, 4=interim billing, last claim.

At this time for paper claims, the fourth digit value "7" or "8" will not be processed as an adjustment/void. Until further notice, adjustments (voids/replacements) requested on paper must be submitted using form AK-05. (See the 837I Companion Guide at <https://alaska.fhsc.com/providers/hipaa/guide.asp> for instructions on electronic claim adjustments.)

Some provider types have few valid types of bills that can be used in Field Locator 4. They are Ambulatory Surgery Centers, End Stage Renal Disease Centers, and Home Health Providers. The valid types of bills for these providers are listed below:

- Ambulatory Surgery Center: 0831 – only valid TOB for ASC
- End Stage Renal Disease: 0721 – only valid TOB for ESRD
- Home Health Services: 032x, 033x, or 034x – only valid TOBs for Home Health Services

For Hospice services, the first three digits are 081 or 082, depending on if the services are hospital-based. The first three digits are:

- 081x for hospice, non hospital-based, or
- 082x for hospital-based hospice care.

Claim submission specifics can be found on the First Health Services' Website at <http://alaska.fhsc.com/> Providers / Updates / New UB-04 Claim Form Instructions or <http://alaska.fhsc.com/> Providers / Billing Manuals / New UB-04 Claim Form Instructions. To obtain a National Uniform Billing Committee Manual, call (312) 422-3390 or go to <http://www.nubc.org>.

Field 57 on the UB-04 Institutional Billing Form

Field Locator 57 on the UB-04 claim form is the designated space to enter the billing provider's Medicaid Contract ID (formerly known as Medicaid Provider ID) number.

Some providers allow non-Medicaid-ID text to flow into Field 57, which could cause a claim to pend or deny. Please review claim forms you file to ensure Field 57 contains only the Billing Provider's Medicaid ID number. Your claims will be processed faster and more accurately when all relevant information can be read.

Refer to "New UB-04 Claim Form" and the "UB-04 New Claim Form Flyer" located at <http://alaska.fhsc.com>. Choose "Providers," then "Updates."

What Providers Need to Know About PERM

PERM, the Payment Error Rate Measurement review of Alaska's Medicaid Program, is a mandatory audit instituted in response to the federal Improper Payments Information Act of 2002.

All states are reviewed on a rotating basis once every three years. Alaska's first review period will begin in January 2008 and continue throughout the year. If your patient records are selected for review, please bear in mind the following points:

- Documentation requested will be for claims paid by Medicaid from Oct. 1, 2007, through Sept. 30, 2008.
- Requests for medical records will come from Livanta, the contractor hired by the Centers for Medicare and Medicaid Services (CMS) to conduct the review.
- Sharing patient records with Livanta for review is not a breach of patient privacy. In fact, you are required by federal law to provide these records.
- Documentation must be submitted within 60 days of Livanta's request. You are required to provide complete and accurate information within the required time. Incomplete documentation will be considered an error.

Past PERM studies have shown that the reasons for most payment errors are no response or insufficient documentation. Even legitimate claims count as errors if CMS doesn't receive the requested medical record documentation on time.

Additional information can be obtained by visiting the State of Alaska Website at: <http://www.hss.state.ak.us/perm/>. If you have any questions about PERM, please contact Randall Schlapia, Deputy Director, Division of Health Care Services at (907) 334-2461.

Why "Inactive Status" Occurs

Provider ID numbers that reflect no activity for at least 18 months will receive an enrollment status letter which requires a response. Providers receiving this letter must choose whether to continue their active enrollment or become inactivated.

Please note that a group practice submitting claims using its Group ID number without indicating the rendering Provider ID number on the claim can cause issuance of this letter. Failure to respond will result in disenrollment.

If you receive notification that your Provider ID number has been inactivated or disenrolled, you **must** re-enroll. To do this, download and print a Standard Provider Enrollment Form from our forms page at <http://alaska.fhsc.com/providers/forms.asp>. Phone Provider Enrollment at (907) 644-6800 or (800) 770-5650 (toll-free in Alaska) if you have any questions.

Correct Completion of the Certificate of Medical Necessity Form

Only physicians, nurse practitioners, or physician assistants are authorized to complete sections "A" and "B" of page "One" of the Certificate of Medical Necessity form. Suppliers are only allowed to complete the top portion of page "One" above Section "A" and all of page "Two." If you have questions, please call FHSC's Provider Inquiry Unit at (907) 644-6800 or (800) 770-5650 (toll-free in Alaska).

Crown and Denture Services Reminder



The State of Alaska and First Health Services would like to remind all dental providers that services such as crowns and dentures are not to be billed until completed and delivered to the recipient.

Also, these services are covered under the Enhanced Dental Services so they must be prior authorized. The Enhanced Dental Services Prior Authorization telephone number is (800) 994-7934 or (907) 644-5997; the fax number is (907) 644-9861. Providers may also contact the Enhanced Provider Support Dental Coordinator, July Skud, at (907) 644-6800 or (800) 770-5650 (toll-free in Alaska).

Qualis Updates the Utilization Management/ Case Management Manual

Qualis Health has updated the Alaska Medicaid Provider Manual for utilization management and case management services. A PDF of the updated manual is available for download at <http://www.qualishealth.org/>.

The PDF is bookmarked for your ease of use; Under the "Care Management" tab, select "Alaska Medicaid", then "Division of Health Care Services", and click on the "Provider Manual" link. Or, you may access the manual directly at: <http://www.qualishealth.org/cm/alaska-medicaid/upload/cmak-07Provider-Manual.pdf>.

If you are unable to access or download the manual and you would like a CD-ROM or a hard copy, please contact Laura Goularte at (800) 949-7536, ext. 2473 or by e-mail at laurag@qualishealth.org.

CMS Clarification of Provider Number Nomenclature

By law, the National Provider Identifier (NPI) will become the only acceptable provider identifier on Health Insurance Portability and Accountability Act of 1996 (HIPAA) Standard Transactions (i.e., claims, remittance advice, eligibility inquiries, prior authorization, and claims status).

However, following NPI implementation, the Medicare/Medicaid Provider Number will continue to be issued to certified providers/suppliers and used to verify Medicare/Medicaid certification on all survey and certification and resident/patient assessment transactions. In order to avoid confusion with the NPI, the Medicare/Medicaid Provider Number has been renamed the CCN (from "Centers for Medicare & Medicaid Services (CMS) Certification Number"). All applicable forms, data entry fields, systems, and manuals are being revised to reflect this new name and the role of the CCN versus the NPI. In some activities, both numbers will be used.

Effective immediately, CMS will use "CCN" to replace the term "Medicare/Medicaid Provider Number" in survey and certification, assessment-related activities, and communications. This terminology change should be explained in those instances. When the NPI is called for on any form or transaction, it should be provided, if available. When the Medicare/Medicaid Provider Number (also known as the Online Survey, Certification, and Reporting (OSCAR) Number; Medicare Identification Number; or provider number) is requested, the CCN should be provided.

NOTE: This policy does not apply to the Clinical Laboratory Improvement Amendments (CLIA) Number which will continue to be used as it has been. **This is a CMS standard; Alaska Medicaid does not use this nomenclature.**

Requesting a Fair Hearing

Recipients or their representatives may request a Fair Hearing if they disagree with an action taken by the Division of Public Assistance or Alaska Medicaid which affects program participation or benefit level.

If the denial pertains to the Medicaid program application or recertification, recipients can contact their nearest Division of Public Assistance office by phone or request a Fair Hearing in writing. They can find the DPA office phone numbers on the inside page of the back cover of the Alaska Medicaid Recipient Handbook.*

If the denial has to do with medical billing or services, they can contact the Recipient Information Helpline at (800) 780-9972 or they can dial Recipient Services at (907) 644-9862. Choose Option 6, "*Recipient Services, including Fair Hearings.*" Before making the call, the recipient should have the following information on hand:

1. The recipient's first and last name and ID number. If they are not the recipient, they must ensure that the recipient or Power of Attorney / Legal Guardian has given their permission for, and is aware of the request for a Fair Hearing.
2. The recipient should have their denial letter handy, if possible. Recipient Services will need to know what was denied and the date on the denial letter. Recipient Services will still take the request if the letter is not available.
3. The recipient's current address and phone number.
4. Recipients who have been receiving benefits will continue to receive benefits at their previous level. If the hearing finds that the adverse action was appropriate, they will be responsible for payment for the continued benefits.

Recipients may also request a Fair Hearing in writing. Include the information listed above in the request, and send it to:

First Health Services Corporation
Recipient Services Department
1835 S. Bragaw St. Suite 200
Anchorage, AK 99508-3469

What happens next?

- Scheduling letters will be received 7-10 days after the date of the request.
- A Position Statement is sent out approximately 5-7 days prior to the Fair Hearing
- Pre-Hearings can be scheduled; this is optional for the recipient.
- The Hearing office may take up to 90 days to come to a decision.
- Any additional information can be faxed at any time before the hearing to (907) 644-5982.

For more information about Fair Hearings or other Medicaid issues, visit the State of Alaska Department of Health Care Services' Website at: <http://hss.state.ak.us/dhcs/> .

*Download the Alaska Medicaid Recipient Handbook here:

http://www.hss.state.ak.us/dhcs/medicaid_medicare/news_medicaid/MedicaidRecipientHandbook1.pdf .

Attention Prescribers and Pharmacies

Effective January 9, 2008, all pharmacy claims for Proton Pump Inhibitors (PPIs) require Prior Authorization (PA) from the prescriber. The PA may be obtained from the First Health MAP Desk by calling (800) 331-4475 or by faxing the General PA form to (888) 603-7696. The General PA form can be found at:

http://www.hss.state.ak.us/dhcs/pdl/forms_pdl/form_0707pa_form_general_pdl.pdf

February Training for Providers

First Health Services provides Alaska Medical Assistance billing training.

These free training classes are sponsored by the State of Alaska. We encourage billers, direct practitioners, health care providers, office managers, admitting or front-desk staff, utilization review staff, case management staff, or other official personnel to attend.

February classes are listed in date order below:

305	Durable Medical Equipment	1 ½ hrs	02/21/2008	TELE	8:30 A.M.	10:00 A.M.
205	TPL Avoidance	1 hr	02/21/2008	TELE	1:00 P.M.	2:00 P.M.
304	Dental Services	1 hr	02/22/2008	TELE	10:30 A.M.	11:30 A.M.
101	Introduction to Alaska Medical Assistance	3 ½ hrs	02/26/2008	ANCH	8:30 A.M.	12:00 P.M.
110	Guidelines for Recordkeeping and Potential Audits	1 hr	02/26/2008	ANCH	1:30 P.M.	2:30 P.M.
102	Eligibility	1 hr	02/26/2008	ANCH	2:45 P.M.	3:45 P.M.
109	Prior Authorization (PA)	1 hr	02/27/2008	ANCH	8:30 A.M.	9:30 A.M.
111	Electronic Transactions	1 hr	02/27/2008	ANCH	12:45 P.M.	1:45 P.M.
104	Completing Claim Forms: CMS-1500	1 hr	02/27/2008	ANCH	2:00 P.M.	3:00 P.M.
103	Completing Claim Forms: UB-04	1 hr	02/27/2008	ANCH	3:15 P.M.	4:15 P.M.
106	Remittance Advice (RA)	1 hr	02/28/2008	ANCH	8:30 A.M.	9:30 A.M.
107	Resubmission Turnaround Documents (RTD)	1 hr	02/28/2008	ANCH	9:45 A.M.	10:45 A.M.
202	Adjustments & Voids	1 hr	02/28/2008	ANCH	11:00 A.M.	12:00 P.M.
108	Appeals	1 hr	02/28/2008	ANCH	1:30 P.M.	2:30 P.M.
206	Edit Resolution	1 hr	02/28/2008	ANCH	2:45 P.M.	3:45 P.M.
208	Transportation & Accommodation	1 hr	02/28/2008	ANCH	4:00 P.M.	5:00 P.M.

ANCH = Anchorage
TELE = Teleconference

You may register for classes offered on the First Health Services Website at <http://alaska.fhsc.com>; choose **Training**, then **Online Registration**. You will receive a confirmation notice that you are registered for the class. You may also complete the registration form located on <https://alaska.fhsc.com/providers/Training/providerTraining.asp> and return it to FHSC via fax, email, or mail. The fax number is (907) 644-9845. The email address is anctraining@fhsc.com. The mailing address is:

First Health Services Corporation
Attention: Training Unit
P.O. Box 240808
Anchorage, Alaska 99524-0808

Due to limited seating, we cannot guarantee a seat if you are not registered. If you are unable to access the FHSC Website to obtain the registration information, please contact the provider trainers at (907) 644-6800 or (800) 770-5650 (toll-free in Alaska).