Banner
University Health Plans

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www.BannerUHP.com

July 2021 Provider Update

Emergent admission process to change Oct. 1

Effective October 1, 2021, BUHP will be sunsetting the emergent admission process of Banner members admitted to Behavioral Health Residential Facility (BHRF), Therapeutic Foster Care (Child), Adult Behavioral Health Therapeutic Home (ABHTH) and Behavioral Health Inpatient Facility (BHIF). Prior authorization for all admissions will be required. The last day Banner will review notifications for Emergent Admissions will be on Sep. 30, 2021.
Arizona's Medicaid program is a leader in the nation in adjusting Medicaid rates to ensure its members are vaccinated, and the first state to adjust NEMT rates to account for wait times at drive-through vaccination sites. AHCCCS serves approximately 30 percent of Arizonans.

AHCCCS: Provider Enrollment process change

Effective August 1, 2021, the Division of Member and Provider Services, Provider Enrollment will no longer accept paper submitted updates/modifications via mail, email or fax.

Provider Enrollment transitioned from a paper process to the AHCCCS Provider Enrollment Portal (APEP) in the summer of 2020 and continues to standardize enrollment processes to improve the overall processing time. As the online application system approaches its one year anniversary, the agency is moving toward an entirely electronic process that eliminates paper.

A modification, also known as an update or change request, is any type of change required to maintain the active provider ID. Modifications include changes to address(es), telephone number(s) demographics, license/certificate updates, etc.

Note:
At this time the APEP system is unable to accept online modifications for Non-Emergency Transportation and Attendant Care providers who report employees. Please continue to submit these via paper.

Providers will need the following items to submit the modification in APEP:

- A username and password, referred to as the Single-Sign-On (SSO),
- The temporary 14 digit application ID, (only needed if the re-registration has not been completed), and
- If the re-registration has already been approved, the user may need domain permission to submit the modification on behalf of the provider.

For assistance on creating the Single-Sign-On (SSO) or submitting a modification, please review the APEP training materials available on the AHCCCS website at azahcccs.gov/APEP.

For assistance on requesting the temporary 14 digit application ID or requesting domain permission, Please contact Provider Assistance at (602) 417-7670, option 5, or email Provider Enrollment at APEPTrainingQuestions@azahcccs.gov.

Provider Relief Fund Reporting

The Health Resources & Services Administration (HRSA) reminds providers who received one or more payments exceeding, in the aggregate, $10,000 in Provider Relief Funds (PRF) during a Payment Received Period that they are required to report as part of the post-payment reporting process. The Provider Relief Fund Reporting Portal (link: https://prfreporting.hrsa.gov/s/) is now open for reporting on the use of funds. Providers required to report during Reporting Period 1 have until September 30, 2021 to submit their information in the portal.

To support providers, HRSA has extended the reporting deadline to 90 days and has created additional resources to help providers report, including a stakeholder one-pager (link: https://bit.ly/3e2RBZH) and stakeholder toolkit (link: https://bit.ly/3xyAzKt).

Hotline offers free help for seniors on utility bill discounts, groceries and other services

Banner Olive Branch Senior Center offers help to seniors throughout Arizona

High temperatures mean higher utility bills and Banner Olive Branch Senior Center, in partnership with the National Council on Aging, is offering eligible Arizona seniors help on getting discounts on their utility bills and to sign up for other services.

Through the Supplemental Nutrition Assistance Program (SNAP), Arizona seniors can call **(623) 465-6005** to get advice about discounts on utility bills, groceries and other items.

Callers don't have to be senior-center members to receive this service; it is free and available to seniors throughout Arizona.

Claims Update Reminder

Change to BUHP pre-adjudication claims process

BUHP and other AHCCCS Health Plans are required to follow AHCCCS guidelines in claims processing and procedure. BUHP has identified four common processing errors that approve payments that later result in a recoupment.

Most common reasons for denial:

- NPI not registered with AHCCCS on the Date of Service – Edit P378
- Provider not active on the Date of Service – Edit P281
- Provider type not eligible – Edit 353
- Provider not eligible for Category of Service – Edit 330

Tips to reduce denials

Ensure provider registration and NPI are current with AHCCCS

During the AHCCCS registration process providers are assigned category of service and provider type, based on the licensing submitted by the provider. Furthermore, AHCCCS mandates that prior to payment of claims, Health Plans ensure providers have an NPI registered with AHCCCS on the date of service and that the billing provider be active on the date of service.

Ensure AHCCCS has the correct Category of Service (COS) registration for services billed
As provider groups grow and/or change, licensing may change. Licensing changes must be submitted to AHCCCS to ensure the causes for the Encounter Edits are corrected prior to providing services. When not updated in a timely manner or if there is a lapse in registration, claims payments are impacted. For providers that have been impacted, AHCCCS may grant retrospective approval.

Determine if provider type is eligible to bill
Some provider types are not eligible to submit claims, so it is important to verify provider type to avoid future claims denials.

Address questions about other information that can affect billing practices
Other factors can impact billing practices. Be sure to contact AHCCCS to receive answers to those questions prior to submitting claims.

AHCCCS Contact Information
Provider Enrollment
In Maricopa County: 602-417-7670 and select option 5
Outside Maricopa County: 1-800-794-6862
Out-of-State: 1-800-523-0231
Call Center Hours: Mon.-Fri., 8 a.m.- Noon and 1 p.m. - 4 p.m.

Family-run organizations as a prevention resource for PCPs

Whether you are a parent, caregiver, teacher, physician and/or a provider to someone with complex behavioral, mental health or medical needs, there are prevention supports and services available in your area. These prevention services are interventions that Family-Run Organizations have in place to help individuals and families meet their needs and offer a variety of support. Interventions focus on reducing the risk of a situation turning into an emergency.

Family-Run Organizations employ parents who have real life experience in the behavioral, medical and/or Department of Child Safety (DCS) systems. Family-Run Organizations specialize in providing family support services, working with families in their home or community settings, building advocacy skills, connecting families to resources and additional services to meet the presenting needs.

Family-Run Organizations	Areas Served	Website	Contact Info
Family Involvement Center (FIC)	Phoenix; Prescott; Flagstaff; Tucson	www.familyinvolvementcenter.org	877-568-8468

Mental Ill Kids In Distress (MIKID)	Phoenix; Tucson; Yuma; Casa Grande; Kingman; Bullhead City; Nogales	www.mikid.org	602-253-1240
Caring Connections for Special Needs	Benson; Sierra Vista; Payson; Douglas; Safford; Tucson	www.ccsneeds.com	520-639-9006
Reach Family Services / Alcanza Servicios de Familia	Phoenix	http://www.reachfs.org/	602-512-9000

Also on

Banner website https://www.banneruhp.com/resources/child-and-family-support

Performance Measure Corner

The Purpose of Performance Measures
The Social Security Act (the Act) requires the Secretary of Health and Human Services (HHS) to identify and publish a core set of health care quality measures for Medicaid enrolled adults and for children enrolled in the Children's Health Insurance Program (CHIP).

These measures help the Centers for Medicare & Medicaid Services (CMS) develop a national system for quality measurement, reporting, and improvement. The information gathered from these measures help CMS to better understand the quality of health care that people receive. The Act also requires publication of core set data to consumers so they can help make informed decisions about their healthcare selection.

All CMS quality measures and reporting requirements are available online for adults (https://www.medicaid.gov/license/form/6461/4386), children (https://www.medicaid.gov/license/form/6466/4391, and health homes (https://www.medicaid.gov/license/form/6471/120816).

DID YOU KNOW?

According to the Arizona Department of Health Services (AZDHS), more than two people die every day from opioid overdoses in Arizona. Within the last four years, 9,719 people in Arizona have died from opiates and 71,280 have overdosed. Daily statistics are recorded and published on the AZDHS website.

Performance Measure Spotlight: Concurrent Use of Benzodiazepines and Opioids
Benzodiazepines are prescription drugs that are categorized as Central Nervous System (CNS) depressants. Benzodiazepines work by inducing a sleepy or calming feeling. Because of this, they are effective for the treatment of anxiety and sleep disorders.

However, these drugs can also severely depress a person's respiratory system if they are taken with other CNS depressants such as opioids. Concurrent use of opioids and benzodiazepines places a person at a high risk for overdose and/or death.

CMS includes concurrent benzodiazepine and opioid use within its adult core measure set. Measure COB-AD was implemented to capture the percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Sample and

calculation guidance in the CMS Technical Specifications and Resource Manual will yield a representative number of patients who have concurrent benzodiazepine and opioid use.

Currently, there is no minimum performance standard (MPS) to determine compliance for this measure but given the known risks for concurrent use, lower rates are always the primary goal. Therefore, this data serves as a dashboard indicator to gauge trends and to evaluate service effectiveness.

Risk Mitigation

CMS emphasizes that this measure is not intended for clinical-decision-making. For clinical guidance on opioid prescribing, please see the ***Center for Disease Control and Prevention CDC Guideline for Prescribing Opioids for Chronic Pain and Guideline Resources***.
Link: https://bit.ly/2SRUGEk

Sources:
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Concurrent-Use-of-Opioids-and-Benzodiazepines-in-a-Medicare-Part-D-Population-CY-2015.pdf
https://www.azdhs.gov/prevention/womens-childrens-health/injury-prevention/opioid-prevention/index.php

Making the Rounds Lectures

Innovations in Tendon Nerve Procedures for Joint Pain
Thursday, July 29 from noon to 1 p.m.
Joshua Hustedt, MD, MHS, Hand & Orthopedic Surgeon
Link: https://bit.ly/3yqR37B

If you missed any of the recent **Making the Rounds** lectures, you can view the recordings on YouTube.

Cancer Immunotherapy for the Non-Oncologist: Genitourinary Medical Oncologist Dr. I. Alex Bowman
(link: https://www.youtube.com/watch?app=desktop&v=XrsTPR1IqFU

Urological Issues Affecting Men and Restoring Function: Urologist Dr. Sunchin Kim
(link: https://www.youtube.com/watch?v=csZO6gJk7i8)

Atrial Fibrillation: When should rhythm control be considered? Electrophysiologists Drs. Shane Rowan and David Bicknell
(link: https://www.youtube.com/watch?v=KaMXyQ3uB84)

Maternal & Child Health

Maternal MAT Directory

The BUHP Maternal Medication Assistant Treatment (MAT) directory is now available for providers. This directory identifies MAT services available through contracted providers, to assist in treatment of Substance Use Disorders for our pregnant and postpartum members.
The Maternal MAT directory lists agencies contracted with BUHP. Each Maternal MAT provider listing includes program descriptions, details the AHCCCS covered services they offer, key

contact and referral information. Available services may include: Crisis Stabilization, Service Plan Development, Initial and Ongoing Crisis Planning, and support for unique populations.

BUHP has High-Risk Obstetric Care Managers available to assist you in coordinating your member's care. Please contact our Customer Care dept @ 1-800-582-8686 and ask to speak to an OB Care Manager or you can send a referral to our MCH referrals mail box at BUHPMaternalChildHealth@bannerhealth.com.

To access the new BUHP Maternal MAT Directory, use the following link: buhp_mat-pregnancy-directory_05202021.ashx (banneruhp.com)

For additional General Mental Health/ Substance Use providers, please refer to https://www.BannerUFC.com/ACC Provider Look-Up tool.

If you have any questions about the agencies listed or if you would like to be added to the MAT directory please contact Adult System of Care at ASOC@bannerhealth.com.

Mental Health Screening and Assessment Tools for Primary Care

BUHP is committed to coordination of care for members to ensure optimal integrated care to meet their needs. Some members may have complex behavioral health (BH) and physical health conditions that require integrated treatment approaches and interventions to improve the member's health. Primary Care Providers (PCPs) are required to screen all members for depression, drug and alcohol misuse, anxiety and suicide risk at least annually or whenever symptoms are present. Assessments should be conducted with age appropriate and standardized evidence-based tools. The intent of the screening tools for PCPs is to help identify the presence of BH conditions and determine if the member's needs require specialized services beyond the PCP's scope.

You can find a comprehensive list of PCP Screening and Assessment Tools for BH at: https://www.banneruhp.com/materials-and-services/behavioral-health.

If the member may benefit, PCPs can complete the PCP Referral to BH Provider located at: https://www.banneruhp.com/materials-and-services/behavioral-health.

A referral from the PCP is not required if the member would prefer to contact a BH Provider directly or to outreach BUHP Customer Care at (800) 582-8686. The benefit of completing the PCP Referral to BH Provider is that a BUHP Care Manager will be assigned to the member for additional support as needed.

Children's System of Care

The Child and Family Support page includes the following updated resources for behavioral health providers: https://www.banneruhp.com/resources/child-and-family-support.

- Children's Specialty BH Provider Directory for specialty services in Central and Southern Arizona
- School-Based BH Service lists for Southern Arizona
- Birth to Five resources
- Birth to Five High Needs Determination Tool
- Transition Age Youth (TAY) resources

- TAY Tool for transition planning
- TAY Checklist for transitioning to adulthood
- Anti-Human Trafficking treatment and resources
- LGBTQ+ resources
- Adopted child and family resources
- Suicide prevention resources
- Family and community resources and more

If you are not currently listed in the Children's Specialty BH Provider Directory or the School-Based BH Service lists and would like to be added, please contact Program Coordinator, Jennifer Blau, at Jennifer.blau@bannerhealth.com. For questions regarding resource guides or Transition Age Youth, contact Program Coordinator, Mayra Lopez, at Mayra.lopez@bannerhealth.com.

Workforce Development

Monthly ACC/RBHA Workforce Development Provider Forum

Every month, the Workforce Development Alliance team hosts a provider forum to provide updates, resources and information for Behavioral Health providers contracted under the ACC and/or RBHA lines of business.

When: Second Thursday of every month, 11:00 AM – 12:30 PM AZ

- **To join the WebEx** event as an attendee, click here: https://azahp.webex.com/azahp/j.php?MTID=m3ee1d19af510530e4113d67e15e43b1d
- **Meeting Number:** 962 089 953
- **Password:** Rp4wiQeKA95
- **Join by Phone:** 1-602-666-0783 ; Code: 962 089 953

ACOM 407 Attachment A Requirement

As a contractor, we are responsible to produce a Network Workforce Development Plan for each line of business (ACC, ALTCS E/PD, DCS/CMDP, DES/DDD, DCS/CHP and RBHA). A portion of this is currently being supported by the AzAHP Workforce Development Plan which some of you have recently completed. The upcoming survey compliments the AzAHP process but also accomplishes other required aspects from ACOM 407 Attachment A; a network workforce profile and a workforce capacity assessment. Completing this survey will help us gather the necessary data to not only provide AHCCCS with the current situation, but also give us insight as to where we can help implement improvements across the network.

In an effort to ensure everyone is aware of the new ACOM 407 Attachment A requirement, we will be offering four webinars to provide information regarding the Survey:

The available dates are:
- Monday, August 2nd 10:00 am - 10:45am
- Tuesday, August 10th 11:00 am - 11:45 am
- Thursday, August 19th 1:00 pm – 1:45 pm
- Friday, August 27th 2:00 pm – 2:45 pm
-

NOTE: All webinars will provide the same information, but you are welcome to attend more than one

Please register through Eventbrite

ACOM 407 Attachment A Webinar - https://www.eventbrite.com/e/acom-407-attachment-a-workforce-survey-tickets-160842547389

If you are unable to register using the link above, choose the day and time that best fits your schedule from the list above, add this to your own calendar and save the Zoom meeting link and password (listed below).

ACOM 407 Attachment A Zoom Link:
https://centene.zoom.us/j/98197349042?pwd=ZXRaNWQxRnVWRmgyQ09yY05ZMjZkZz09#succesSeting - Zoom
Password: 516089

**Please note the information is being shared amongst the plans; thus, the ACOM 407 Attachment A survey is only required for your agency to fill out ONCE.

Provider Relations

Member Rosters

To access member enrollment information and obtain member rosters, please visit https://eservices.uph.org/. For more information about eServices, contact your Provider Relations Representative.

For inquiries related to obtaining information regarding the provider's assigned membership, please send to our dedicated inbox at BUHPProviderNotifications@bannerhealth.com

Access to Timely Care

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey asks patients to report on and evaluate their experiences with health care and their provider. One important component focuses on getting appointments and care quickly. AHCCCS also has a set of required appointment standards. Ensuring your office meets these standards increases the patients positive experience with your office and healthcare. Ease of getting needed care impacts overall health care quality for our members.

BUHP has made a commitment to meet appointment availability standards as set forth by AHCCCS, Medicare and community standards; see chart of standards below. In accordance with AHCCCS and Medicare standards, appointment standards/wait time audits are conducted regularly to ensure members have timely access to care. Should providers not meet appointment or wait time standards, a Corrective Action Plan will be issued.

Note: BUHP utilizes a contracted vendor (Contact One) to conduct appointment availability surveys on a quarterly basis. Please share the appointment standards below with your staff. You may designate a representative in your office to complete the quarterly appointment availability survey with Contact One to alleviate confusion.

If you have any questions on implementing this in your office, please reach out to your Provider Relations Representative.

Appointment Standards		
PROVIDER TYPE	**URGENT**	**ROUTINE**

Primary Care Provider (PCP)	No later than 2 business days of request	Within 7 calendar days for non-urgent but in need of attention (SNP) only. Within 21 calendars of request for routine physicals or health maintenance visits
Specialty Provider Referrals	No later than 2 business days of request	Within 45 calendar days of referral
Dental (AHCCCS Oral Health Care is a covered service for AHCCCS members between birth and age 21)	No later than 3 business days of request	Within 45 calendar days of referral
Maternity	High risk pregnancies – no later than 3 business days of identification of high risk by contractor or immediately if an emergency exists	Initial prenatal care appointments 1st trimester – within 14 calendar days of request 2nd trimester – within 7 calendar days of request 3rd trimester – within 3 business days of request Within 45 calendar days for routine care (SNP) Uncomplicated pregnancy – every 4 weeks for the first 28 weeks and every 2 – 3 weeks until 36 weeks of pregnancy and weekly thereafter One postpartum visit at approximately 6 weeks after delivery.
Behavioral Health Providers	No later than 24 hours from identification of need	Initial assessment within 7 calendar days of referral or request for service For members 18 years or older – 1st service following assessment no later than 23 calendar days after initial assessment For members under the age of 18, no later than 21 days after the initial assessment All following services no later than 45 calendar days from identification of need
Psychotropic Medications	Urgency will be assessed immediately	Appointment within a timeframe that ensures member does not run out of needed medication or decline in behavioral health condition, but no later than 30 days from the identification of needs

Provider Manuals: All Banner University Health Plans provider manuals can be accessed on the Health Plans website: https://www.banneruhp.com/.

A printed copy of the manuals will be provided upon request, please contact your Provider Relations Representative.

Notify the Health Plan Data Department of the below updates: According to provider standards and responsibilities, providers must notify plan with any changes to:

- Provider and Provider Group Adds
- Provider or Group Location demographic updates (except terms)
- Provider Panel Changes
- Telephone numbers

This notification should occur within 30 days of any of the above noted changes. Please send all updates and changes via the online Provider Update Form located at https://www.banneruhp.com/materials-and-services/provider-data-update-form or you may email to BUHPDataTeam@bannerhealth.com.

Notify the Health Plan Provider Relations Department of the below updates: According to provider standards and responsibilities, providers must notify plan with any changes to:

- Practitioner or Provider (Group) Termination
- Key contacts
- Tax Identification Numbers
- Corporate structure

This notification should occur as soon as possible, please send your request to BUHPProviderNotifications@bannerhealth.com.

Annual Attestation and Disclosure Statement

All BUHP contracted providers and subcontractors are required to complete the Annual Attestation and Disclosure Statement.

Instructions:

1. Review each section
   - Section 1: Medicare and Medicaid Participation Compliance Program Requirements
   - Section 2: Attestations
   - Section 3: Organization Information and Signature
2. Complete the 2021 Annual Attestation online here: https://eservices.uph.org
   *If you are unable to complete the online form above, below is the PDF version.
   2021 Annual Attestation Form (link: https://bit.ly/3dWrrHI)
3. Complete the Offshore Subcontracting Attestation if contracting with offshore entity.
   2021 Offshore Subcontracting Attestation (link: https://bit.ly/3hOUkqD)

Compliance Corner

Fraud, Waste and Abuse (FWA)

Banner Medicaid and Medicare Health Plans are committed to preventing Fraud, Waste, and Abuse (FWA). If you suspect a member, a provider, a contractor, or an employee of potential FWA or non-compliance, you are required to report it.

What is a simple definition of Fraud, Waste, & Abuse?

Fraud is purposely giving wrong or misleading information in order to get a benefit or some type of service.
Waste is overusing services or misusing resources or practices.
Abuse of the Program is provider practices or member practices that result in an unnecessary cost to the AHCCCS or Medicare program.

Examples of Fraud, Waste, and Abuse

Provider Fraud, Waste, and Abuse include, but are not limited to:

- Ordering tests, lab work, or x-rays that aren't needed.
- Charging for medical services not provided.
- Billing multiple payers and receiving double payments.
- Using billing codes that pay higher rates to get more money even though those services weren't provided.
- Billing for services under a member who is not their member.
- Providing unnecessary medical services leading to unnecessary costs to the program.
- Use of the Medicaid or Medicare system by someone who is unqualified, unlicensed, or has lost their license.

Current Activity to Combat Fraud

Since 2019, the Department of Justice Healthcare Fraud Unit has focused on telemedicine fraud in a nationwide effort. This fraud section has charged 73 defendants which involved over $3.7 billion in alleged fraud. With these cases, telemedicine executives allegedly paid doctors and nurse practitioners to order durable medical equipment, genetic and other diagnostic testing, and pain medications that were not medically necessary. In these schemes, the providers had either no patient interaction or very minimal telephone calls with individuals they had never met or seen. In September 2020, this Fraud Unit in conjunction with USAO partners completed a takedown and charged 80 defendants that involved fraudulent claims related to telemedicine and over $4 billion.

Another area of focus the Healthcare Fraud Unit has is chairing an interagency COVID-19 fraud work group to both identify and combat health care fraud trends that manifested during the COVID-19 crisis. They expect criminal prosecutions to address COVID-19 test bundling schemes, and securities fraud cases involving health care technology companies.
The Arizona Medicaid Fraud Control Unit (MFCU) works closely with other State Agencies such as the AHCCCS Office of Inspector General. In 2020, the AZ MCFU conducted 250 investigations and 203 of those were fraud related. The total recoveries in 2020 were $15,525,961.

AHCCCS Self-Disclosure Process

AHCCCS Office of Inspector General (OIG) works with Managed Care Organizations to assist providers in helping to promote the integrity of the Medicaid program. AHCCCS has guidelines to assist providers in self-disclosing when they discover improper payments during an internal audit or review. The self-disclosure protocol and guidance provides valuable information to providers on how to participate in the OIG's Self Disclosure Program. Information on this protocol can be located on the AHCCCS Website
https://www.azahcccs.gov/Fraud/Downloads/SelfDisclosure.pdf

If you identify or suspect offshore activities, immediately notify the Banner Insurance Division Compliance Department at the contacts below.

Contact the Medicaid Compliance Officer Terri Dorazio via phone 520-874-2847(office) or 520-548-7862 (cell) or email Theresa.Dorazio@BannerHealth.com

Contact the Medicare Compliance Officer Linda Steward via phone 520-874-2553 or email Linda.Steward@BannerHealth.com

Banner University Health Plans Contact Information

BUHP Customer Care
Banner - University Family Care – ACC 800-582-8686
Banner - University Family Care – LTC 833-318-4146
Banner - University Care Advantage – SNP 877-874-3930
BUHP Compliance Officers
520-548-7862 (Medicaid) or 520-403-3780 (Medicare)
BUHP Compliance Department FAX 520-874-7072
BUHP Compliance Department Email
BHPCompliance@BannerHealth.com

BUHP Compliance Department Mail:
BUHP Compliance Dept
2701 E Elvira Rd
Tucson, AZ 85756

Confidential and Anonymous Compliance Hotline (ComplyLine)
888-747-7989

Banner Medicare Advantage Customer Care

Prime HMO – 8440-549-1857
Plus PPO – 844-549-1859

AHCCCS Office of the Inspector General
Providers are required to report any suspected FWA directly to AHCCCS OIG

Provider Fraud
602-417-4045

888-487-6686

Member Fraud
602-417-4193
888-487-6686

Website
www.azahcccs.gov (select **Fraud Prevention**)

Mail:
Inspector General
701 E Jefferson St.
MD 4500
Phoenix, AZ 85034

Medicare
Providers are required to report all suspected fraud, waste and abuse to the Health Plan or to Medicare

Phone: 800-HHS-TIPS (800-447-8477)
FAX: 800-223-8164
TYY: 800-377-4950

Website:
https://forms.oig.hhs.gov/hotlineoperations

Mail:
US Department of Health & Human Services
Office of the Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026