

Annual Network

Submission Instruction Manual

Reporting Year (RY) 2025

**Table of Contents**

[Introduction 4](#_Toc179453801)

[A. Definitions 4](#_Toc179453802)

[I. Instructions for Required Annual Reporting 11](#_Toc179453803)

[A. Compliance Officer 11](#_Toc179453804)

[B. Report Form Submission Requirements (Rule 1300.67.2.2(h)(7)) 12](#_Toc179453805)

[1. Validation (Rule 1300.67.2.2(h)(9)) 12](#_Toc179453806)

[C. Network Access Profile Requirements (Rule 1300.67.2.2(h)(8)) 14](#_Toc179453807)

[II. General Instructions Applicable to All Required Report Forms (Rules 1300.67.2.2(h)(7)) 19](#_Toc179453808)

[A. Reporting Data from Subcontracted Plans 19](#_Toc179453809)

[B. Reporting Multiple Entries for the Same Data Field 19](#_Toc179453810)

[C. Reporting with Standardized Terminology (Rule 1300.67.2.2(h)(8)(D)) 20](#_Toc179453811)

[III. RESERVED 23](#_Toc179453812)

[IV. RESERVED 24](#_Toc179453813)

[V. Annual Network Report Forms 25](#_Toc179453814)

[A. Network Service Area and Enrollment Report Form (Form 40-265): Instructions 26](#_Toc179453815)

[B. PCP and PCP Non-Physician Medical Practitioner Report Form (Form No. 40-266): Instructions 31](#_Toc179453816)

[C. Specialist and Specialist Non-Physician Medical Practitioner Report Form (Form No. 40-267): Instructions 38](#_Toc179453817)

[D. Mental Health Professional and Mental Health Facility Report Form (Form No. 40-268): Instructions 45](#_Toc179453818)

[E. Other Outpatient Provider Report Form (Form No. 40-269): Instructions 53](#_Toc179453819)

[F. Hospital and Clinic Report Form (Form No. 40-270): Instructions 58](#_Toc179453820)

[G. Telehealth Report Form (Form No. 40-271): Instructions 63](#_Toc179453821)

[H. Timely Access and Network Adequacy Grievance Report Form (Form No. 40-272): Instructions 70](#_Toc179453822)

[I. Out-of-Network Payment Report Form (Form No. 40-273): Instructions 73](#_Toc179453823)

[J. Third-Party Corporate Telehealth Provider Report Form (Form No. 40-274): Instructions 76](#_Toc179453824)

[K. Non-Network Provider Arrangements Report Form (Form No. 40-287): Instructions 87](#_Toc179453825)

[1. Non-Network Requests Report Tab (Form No. 40-287): Instructions 87](#_Toc179453826)

[2. Limited Plan Provider Report Tab (Form No. 40-287): Instructions 88](#_Toc179453827)

[VI. Standardized Terminology Appendices 96](#_Toc179453828)

[Appendix A: Product Line Categories 96](#_Toc179453829)

[Appendix B: Provider Types 97](#_Toc179453830)

[Appendix C: Provider Languages 107](#_Toc179453831)

[Appendix D: Type of License or Certificate 115](#_Toc179453832)

[Appendix E: Telehealth Location and Modality Terminology 117](#_Toc179453833)

[Appendix F: Grievance Field Values 118](#_Toc179453834)

## Introduction

The California Code of Regulations, title 28, section 1300.67.2.2 and Health and Safety Code sections 1367.03, 1367.035 and 1371.31 require health care service plans (health plans) to submit to the Department of Managed Health Care (Department), on an annual basis, an Annual Network Report.[[1]](#footnote-2) As part of this reporting, health plans shall annually report grievance data and, as applicable, out-of-network provider data and third-party corporate telehealth data. This Annual Network Submission Instruction Manual (Instruction Manual) sets forth health plan reporting requirements in accordance with these provisions.

## Definitions

The definitions below, and the definitions set forth in Rule 1300.67.2.2 apply to the information in this Instruction Manual:

1. “Accepting new patients” shall have the definition set forth in Rule 1300.67.2.2(b).

2. "Basic hospital services" or “general acute care hospital services” means the services described in the definition of general acute care hospital as set forth in section 1250(a).

3. “Clinic” shall have the definition set forth in section 1200(a).

4. “Clinical encounters” means face-to-face or electronic visits or encounters between the reported provider and a network enrollee, whether reported to the health plan through claims data, encounter data, or otherwise provided to the health plan. It does not include inpatient hospital-based or hospital emergency room-based patient visits or encounters. This does not include appointment scheduling or other non-clinical encounters with a provider. Each patient visit with a provider on a date of service is a clinical encounter, regardless of how many procedures are delivered or billed by the provider over the course of the visit with the patient.

5. “Clinical data capture timeframe” means the timeframe for which the health plan must report clinical encounters. For the purposes of annual network reporting, that timeframe shall be the timely access compliance measurement year. The health plan shall include the network’s clinical encounters that were reported to, or received by, the health plan during the timely access compliance measurement year, regardless of the date of service of the specific encounter. The timely access compliance measurement year is defined in Rule 1300.67.2.2(b)(4)(A).

6. “Crosswalk” or “crosswalk table” is a tool that allows health plans to identify internal terminology that is equivalent to the Department’s required standardized terminology for the data category provided in the crosswalk table. Completion of a crosswalk table allows health plans to report data within the report forms using the health plan’s internal terminology that does not conform to the Department’s standardized terminology. Once a crosswalk table has been completed by a health plan, the health plan’s uploaded report forms will associate the health plan’s internal terminology with the standardized terminology required pursuant to Rule 1300.67.2.2(h)(8)(D).

7. "Entity provider" means an organization comprised of more than one individual provider that delivers a particular health care service to patients.

8. “Facility” means a licensed hospital, ambulatory surgery center, laboratory, radiology or imaging center, or other outpatient setting as described in section 1248.1, and any other facility described under section 1371.9(f)(1).

9. “Full-time” shall have the definition set forth in Rule 1300.67.2.2(b).

10. “Grievance” shall have the same definition as Rule 1300.68(a)(1) and (2). When collecting grievance data, the Department will rely on the following definitions:

a. “Complaint Categories” means the categories of timely access or network adequacy grievance based on the topic of the enrollee’s complaint, consistent with Rule 1300.68(e)(2). Complaint categories may include the following:

i. Geographic Access - Enrollee complaint regarding distance or travel time to a network provider (e.g. travel distance is too far from home or work, travel time takes too long from home or work).

ii. Language Assistance Plan - Enrollee complaint regarding difficulty obtaining interpreter or translation services from health plan.

iii. Language Assistance Provider - Enrollee complaint regarding difficulty obtaining interpreter or translation services from provider.

iv. Office Wait Time - Enrollee complaint about length of time waiting for the provider during a scheduled appointment.

v. Provider Directory Error - Enrollee complaint that information listed in provider directory is inaccurate (address, phone, accepting new patients, accepting enrollee’s plan, etc.).

vi. Provider Not Taking New Patients - Enrollee complaint that provider is not accepting new patients.

vii. Telephone Access Plan - Enrollee complaint regarding difficulty reaching a live person to talk to at the health plan during or after office hours.

viii. Telephone Access Provider - Enrollee complaint regarding difficulty reaching a live person to talk to at the provider office during or after office hours.

ix. Timely Access - Enrollee complaint regarding difficulty obtaining a timely appointment with a network provider.

x. Timely Authorization - Enrollee complaint regarding difficulty obtaining a timely authorization for a network provider.

xi. Other – Enrollee complaint is regarding a network adequacy issue that is not represented in the complaint categories described above (i.e. those set forth in section (A)(8)(a)(i) through (x) of the Definitions section of this Manual). A health plan shall not report as “Other” any grievance that fits within any of the complaint categories set forth above.

b. “Nature of Resolution” means the action taken by the health plan to resolve the grievance. Resolution actions may include:

i. Authorization Approved - The health plan, or delegated provider, approves an authorization for an appointment with a specialist, hospital, or other type of provider.

ii. Authorization Denied - The health plan, or delegated provider, denies an authorization for an appointment with a specialist, hospital, or other type of provider.

iii. Change Medical Group - The health plan assists the enrollee with assignment to a different Medical Group or IPA.

iv. Change PCP - The health plan assigns the enrollee to a different PCP.

v. Change Specialist - The health plan identifies a different specialist for the enrollee.

vi. Enrollee Educated - The health plan educates enrollee regarding access rules, network rules, etc.

vii. No Confirmed Access Issue - The health plan researches enrollee grievance. Grievance determined not to involve an access issue. No assistance is required to secure timely appointment and no additional communication/education is required for the enrollee or provider.

viii. Out-of-Network Referral - The health plan authorizes an out-of-network referral to meet the enrollee’s needs (for example, through a single-case agreement, letter of intent, or other contracting agreement as set forth in 28 CCR § 1300.67.2.2 subsection (b)(10)(D)).

ix. Provider Educated - The health plan educates/informs provider of access responsibilities.

x. Re-adjudicated claim - The health plan re-processes a claim for services previously received to reflect in-network benefits.

xi. Updated Provider Directory - The health plan researches and/or updates its provider directory as a result of enrollee grievance.

xii. Secured Timely Appointment - The health plan secures a timely appointment for the enrollee.

xiii. Network Provider Added to the Network – The health plan adds one or more network providers to the network, to address access to the covered services identified in the grievance.

c. “Resolution Determination” means the ultimate outcome of the health plan’s resolution of the grievance. Resolution determinations may be made as follows:

i. Enrollee Favor - The health plan's decision is wholly in the enrollee's favor; the health plan agrees to grant the entirety of the enrollee's request(s).

ii. Partial Enrollee Favor - A portion of the health plan's decision is in the enrollee's favor; health plan agrees to grant part of the enrollee's request and denies part of the enrollee's request.

iii. Health Plan Favor - The health plan's decision is wholly in its favor; the health plan denies the enrollee's request in whole.

11. "Individual provider" means a single individual who delivers health care services to patients.

12. “In-person appointments on an outpatient basis” shall have the definition set forth in Rule 1300.67.2.2(b).

13. “Name” when referring to a network provider, means the name appearing on the network provider’s state license or certificate issued to provide health care services. For network providers for which licensure or certification is not required, “name” means the professional name used by the network provider to deliver health care services.

14. “National Provider Identifier” (NPI) means the number(s) associated with a network provider, as registered through the National Plan and Provider Enumeration System.

15. “Network” shall have the definition set forth in Rule 1300.67.2.2(b).

16. “Network capture date” shall have the definition set forth in Rule 1300.67.2.2(b).

17. “Network identifier” shall have the definition set forth in Rule 1300.67.2.2(b).

18. “Network name” shall have the definition set forth in Rule 1300.67.2.2(b).

19. “Network provider” shall have the definition set forth in Rule 1300.67.2.2(b).

20. “Network service area” shall have the definition set forth in Rule 1300.67.2.2(b).

21. “Network tier,” “tiered network,” and “lowest cost-sharing tier” shall have the definitions set forth in Rule 1300.67.2.2(b).

22.“Number of enrollees assigned to a network provider” means the sum of all enrollees within the network enrolled in product lines licensed by the Department, that the health plan, its subcontracted plan, or its delegated provider group has assigned to a network provider, across all of the network provider’s locations within the health plan network.

23. “Non-network provider” means an individual provider, an entity or a facility, as set forth in section 1345(i), that does not meet the definition of network provider in Rule 1300.67.2.2(b)(10).

24. “Non-network provider request” means a request that the enrollee access or receive covered services from a provider that is not a network provider, as defined. Such request may be initiated by an enrollee, enrollee’s representative, a provider, or any other source, including through the grievance process.

25. “Part-time” shall have the definition set forth in Rule 1300.67.2.2(b).

26. “Particularized hospital services” means one or more of the following health care services, when available at a general acute care hospital: abortion services, acute neonatal services, burn services, cancer services, coronary ICU services, heart catheterization services, hemodialysis services, labor delivery room services, neonatal ICU services, neurosurgery services, open heart surgery services, pediatric ICU services, PET scan services, radiation therapy services, and transplant services.

27. “Plan-to-plan contract” shall have the definition set forth in Rule 1300.67.2.2(b).

28. “Practice address” and “practice location or locations” shall have the definition set forth in Rule 1300.67.2.2(b).

29. “Primary care physician” shall have the definition set forth in Rule 1300.45(m).

30. “Primary plan” shall have the definition set forth in Rule 1300.67.2.2(b).

31. “Product line” shall have the definition set forth in Rule 1300.67.2.2(b).

32. “Profile-only plan” means a health plan required to submit only the network access profile on an annual basis, pursuant to Rule 1300.67.2.2(h)(1)(B).

33. “Provider group” shall have the definition set forth in Rule 1300.67.2.2(b).

34. “Standalone network” means a network licensed to contract directly with a group, individual subscriber, or a public agency, to arrange for the provision of health care services.

35. “Subcontracted network” means a subcontracted plan’s network used by a primary plan.

36. “Subcontracted plan” shall have the definition set forth in Rule 1300.67.2.2(b).

37. “Reporting plan” shall have the definition set forth in Rule 1300.67.2.2(b).

38. “Residential Detox Facility” means a facility licensed to provide 24-hour residential nonmedical alcohol and/or drug recovery, treatment, and detoxification services.

39. “Specialty” or “subspecialty” shall have the definition set forth in Rule 1300.67.2.2(b).

40. “Telehealth” shall have the definition set forth in Business and Professions Code section 2290.5(a)(6).

41. “Telehealth modality” means the method by which an enrollee receives telehealth services. Telehealth modality may include direct patient care or provider-to-provider services, in a synchronous or asynchronous interaction.

a. Telehealth modalities may include live two-way video or audio interactions, e-consults, remote patient monitoring, store and forward interactions, remote clinician advice or triage services, or other methods of delivering treatment that meet the definition of “telehealth.”

42. Telehealth “patient location” means the location where a patient may receive telehealth services. The patient location may include a medical facility, the patient’s personal residence, or a personal mobile device.

43. “Unscheduled urgent services” shall have the definition set forth in Rule 1300.67.2.2(b).

44. “Unavailable” when referring to a provider, provider type or health care service shall have the definition set forth in Rule 1300.67.2.2(b).

45. “Urgent Care Center” or “Urgent Care Clinic” means a location, distinct from a hospital emergency room, or provider’s office, whose purpose includes the delivery of unscheduled urgent services, as defined in Rule 1300.67.2.2(b). An urgent care center within a network is staffed by one or more physicians or by one or more non-physician providers acting within the scope of their licensure. An urgent care center does not include retail or similar clinics with a limited scope of service, or physician offices with only selected hours for walk-in unscheduled urgent services. An urgent care center shall have, at a minimum, the after-hours, walk-in diagnostic and treatment services set forth in the unscheduled urgent services definition in Rule 1300.67.2.2(b).

1. “Telehealth urgent care center” means unscheduled urgent services that are appropriate for diagnosis and treatment through a live telehealth modality. Telehealth urgent care does not replace a health plan’s obligation to provide in-person unscheduled urgent care services to enrollees through unscheduled urgent services, and/or an urgent care center. Telehealth urgent care within a network shall have at a minimum the following:

i. Urgent diagnostic and treatment services which can reasonably be performed on an outpatient basis through live telehealth modalities outside of the emergency room setting;

ii. Live telehealth services accessible to enrollees on a same-day, unscheduled basis, or through a queue that provides same-day delivery of telehealth care; and

iii. Availability after-hours or hours of operation outside of the traditional business hours of 8:00 a.m. to 5:00 p.m., Monday through Friday.

# Instructions for Required Annual Reporting

## Compliance Officer

All health plans subject to reporting requirements under Rule 1300.67.2.2(h)(1)(A) shall submit annually an Annual Network Report, as set forth in Rules 1300.67.2.2(h)(2), (h)(7) and (h)(8). To complete the submission of this report, health plans shall designate an individual as a compliance officer, complete or update required information within the network access profile, and submit required annual report forms within the Department’s web portal. (Rule 1300.67.2.2(h)(2).)[[2]](#footnote-3) Health plans subject to reporting requirements under Rule 1300.67.2.2(h)(1)(B) shall complete and submit information within the network access profile within the web portal, set forth in Rule 1300.67.2.2(h)(8). The health plan shall designate an individual as a compliance officer, and the designee shall verify the accuracy of the information provided to the Department within the annual submission. (Rule 1300.67.2.2(h)(2).) Health plans may contact the Department through the messages section of the web portal.

**Networks with no Enrollment**

If a reporting plan maintains a network in which there is no enrollment on the network capture date and the health plan does not anticipate enrollment during the reporting year, the reporting plan may request a waiver of the requirement to submit to the Department all information set forth in Rule 1300.67.2.2, sub. (h)(7) for that network by submitting a Notice of Material Modification filing prior to the network capture date of the reporting year. When evaluating whether to grant the waiver, the Department may consider the following factors:

* The date the network last had enrollment;
* Whether the health plan anticipates enrollment during the reporting year;
* The date the health plan last submitted its network for review by the Department through an Amendment or Material Modification, pursuant to Sections 1351 and 1352 and Rules 1300.51 and 1300.52; and
* The date the health plan last submitted its network for review by the Department pursuant to Rule 1300.67.2.2.

Any Order issued by the Department approving a waiver will include a condition requiring the health plan to submit an annual Amendment filing renewing the waiver request for subsequent reporting years. In each annual Amendment filing, the health  
  
plan will be required to affirm that the network continues to not have associated enrollment and the health plan does not anticipate enrollment over the course of the measurement year.

The health plan shall continue to submit the network access profile information set forth in Rule 1300.67.2.2, sub. (h)(8) regardless of whether a waiver is granted with respect to the information set forth in the Annual Network Report, as set forth in Rule 1300.67.2.2, sub. (h)(7).

## Report Form Submission Requirements (Rule 1300.67.2.2(h)(7))

Report forms provided by the Department in the web portal are the only allowable format for a health plan to submit required data for the Annual Network Report. Health plans shall not submit information or data outside of the posted report forms, unless expressly permitted to do so by the Department. Required report forms include the following:

1. Annual Network Report Forms (Form Nos. 40-265 through 40-272, and 40-287), required for Annual Network data.

2. Annual Out-of-Network Payment Report Form (Form No. 40-273), required for health plans that do not exclusively contract with the Medi-Cal program. (See section 1371.31(a)(4) and (e).)

3. Third-Party Corporate Telehealth Provider Report Form (Form No. 40-274), required for health plans that do not exclusively contract with the Medi-Cal program. (See section 1374.141.) Please see section V.J. of this Manual for further information.

### Validation (Rule 1300.67.2.2(h)(9))

To submit the report forms and satisfy annual reporting requirements, the health plan shall complete the network access profile and upload all required report forms into the web portal. Prior to submission, the uploaded report forms shall pass the Department’s automated validation for completeness and accuracy, as described in Rule 1300.67.2.2(h)(9).

**Note:** The Department’s validation does not ensure that a health plan’s Annual Network Report submissions are free from errors, omissions, conflicting data or data submitted contrary to instructions. Even where the health plan’s Annual Network Report passes the Department’s automated validation, the Department may further identify inaccuracies, inconsistencies or omissions in the submission, and require the health plan to correct the submitted data, or make a finding of non-compliance under Rule 1300.67.2.2(i).

The report form may not pass validation and the submission may fail under the following circumstances:

1. The report form fields contain information or data that conflicts with the requirements set forth in Rule 1300.67.2.2 or the Field Instructions set forth in the [Annual Network Report Form](#_Annual_Network_Report) sections of this Instruction Manual;
2. The report form is missing information or data that is required under Rule 1300.67.2.2 or this Instruction Manual;
3. The report form contains information that conflicts with standardized terminology requirements, described in Rule 1300.67.2.2(h)(8)(D);
4. The report form contains information or data that conflicts with other information or data reported by the health plan through the Department’s web portal, including the following:

a. Network identifiers, network names, product lines, and plan-to-plan contracts specified in the network access profile conflict, or are not included in the appropriate fields of the Annual Network Report Forms;

b. The health plan used a crosswalk table to associate the health plan’s internal terminology to the Department’s required standardized terminology, but did not report data using the same terms it entered within the crosswalk tables; or

c. Counties identified as part of the network service area in the network access profile are not consistent with the counties and ZIP Codes reported in the Network Service Area Report Form.

1. The report form contains information that conflicts with established sources such as the NPI Registry, the California Department of Consumer Affairs, or the United States Postal System, and other sources as set forth in Rule 1300.67.2.2(h)(8)(D). For example, the report form contains deactivated NPI or California license numbers, or erroneous ZIP Code and county combinations, preventing the report form from passing validation.

Additionally, the health plan’s submission will not pass validation if the submission does not contain all report forms identified by the health plan as comprising the entirety of the health plan’s Annual Network Report in the network access profile. A health plan’s submission will not pass validation if it does not include a Network Service Area Report Form.

Once the health plan uploads and attempts to validate a report form in the web portal, the health plan shall receive an error report identifying the error and each entry that failed to pass validation, if applicable.

## Network Access Profile Requirements (Rule 1300.67.2.2(h)(8))

All health plans subject to reporting requirements under Rules 1300.67.2.2(h)(1)(A) and (h)(1)(B) shall complete or update the network access profile within the Department’s web portal. Health plans subject to reporting requirements under subsection (h)(1)(A), shall complete the network access profile prior to submitting the required annual report forms, as described in Rules 1300.67.2.2(h)(1) and (h)(8). Failure to provide complete and accurate information within the network access profile may cause the health plan’s annual submission to fail, requiring the health plan to correct or complete the network access profile data and resubmit corresponding report forms, if applicable.

Prior to completion of the network access profile, the health plan shall specify whether it is a reporting plan or a profile-only reporting plan pursuant to Rule 1300.67.2.2(h)(1). A health plan that serves as both a reporting plan pursuant to Rule 1300.67.2.2(h)(1)(A), and a subcontracted plan or specialized plan pursuant to Rule 1300.67.2.2(h)(1)(B), shall complete a single network access profile once each reporting year as a reporting plan. All information relevant to that health plan’s status as both a reporting plan and a subcontracted or specialized plan must be represented within the network access profile, as required under Rules 1300.67.2.2(a)(2), (h)(1), & (h)(8). If the Department has granted the health plan a waiver from some or all the reporting requirements of Rules 1300.67.2.2(h), the health plan must still complete the network access profile.

The network access profile is pre-populated with the network information submitted by the health plan in the previous year. On an annual basis, health plans subject to reporting requirements under Rule 1300.67.2.2(h)(1)(A) shall complete or update the information within the health plan’s network access profile for each reported network, as set forth in items 1 through 8 below. Within the web portal, these health plans shall complete the following sections of the network access profile:

* The ANR Profile tab for the applicable Annual Network Report measurement year and network capture date, for reporting plans.
* The crosswalk tab for the Annual Network Report network capture date, as applicable.

Rules 1300.67.2.2(b)(4) and (b)(7) define the applicable measurement years and network capture date, unless otherwise specified in the Rule and in the report form field instructions for a particular report form.

For profile-only plans, on an annual basis,health plans subject to reporting requirements under Rules 1300.67.2.2(h)(1)(B) shall complete or update the information within the health plan’s network access profile for each reported network, as set forth in items 1, 3 through 5, and 8, below. Within the web portal, these health plans shall complete the following sections of the network access profile:

* The ANR Profile tab of the network access profile, for the applicable Annual Network Report reporting year and network capture date, for profile-only plans.

A health plan that serves as both a reporting plan pursuant to Rule 1300.67.2.2(h)(1)(A), and a subcontracted or specialized plan pursuant to Rule 1300.67.2.2(h)(1)(B), shall complete the network access profile only once for each year, as a reporting plan. On an annual basis, a health plan subject to reporting requirements under both Rule 1300.67.2.2(h)(1)(A) and Rule 1300.67.2.2(h)(1)(B) shall complete or update the information within the health plan’s network access profile for each reported network. The health plan shall complete items 1 through 8, below, pursuant to its obligations as a reporting plan under Rule 1300.67.2.2(h)(1)(A), and shall complete items 1, 3 through 5, and 8 below pursuant to its obligations as a subcontracted plan under Rule 1300.67.2.2(h)(1)(B). Within the web portal, the health plan shall complete the reporting requirements for reporting and profile-only plans, as applicable to the network reported.

1. **Network Name and Network Identifier** (Rule 1300.67.2.2(h)(8)(B))

The health plan shall report each network by listing the Department’s assigned network identifier for the network, consistent with the definition of these terms in Rules 1300.67.2.2(b)(5) and (b)(8). The Department will provide an updated list of networks and network identifiers within the web portal on an annual basis. If, since the previous network capture date, a health plan has removed, added or otherwise changed the network in a manner that would require a filing under section 1352 and Rules 1300.51 or 1300.52.4, the health plan shall list the network identifier and provide the filing number verifying the change, and other available information describing the reason for the change.

The health plan shall report the network name for the network, consistent with the definition of these terms in Rule 1300.67.2.2(b)(5) and (b)(9). (See Rule 1300.67.2.2(h)(8)(B).)The health plan shall indicate the Department’s assigned network identifier associated with the reported network name.

The health plan shall identify whether the reported network had enrollment as of the network capture date, and if not, the last date of enrollment within the network. The health plan shall also identify whether some or all of the enrollment in the network was delegated to a subcontracted plan, or delegated from a primary plan (if the health plan is a subcontracted plan).

1. **Network Information** (Rule 1300.67.2.2(h)(8)(A))

The health plan shall indicate whether the network is a standalone network or a subcontracted network, as defined. If the network is a standalone network that has been waived from reporting for the measurement year, or it is otherwise not required to be reported, the plan shall indicate the current eFiling order, or otherwise explain why data for the network is not required to be reported.

1. **Product Lines** (Rule 1300.67.2.2(h)(8)(C))

For each health plan network, the health plan shall report all product lines consistent with the standardized terminology in **Appendix A**. (Rules 1300.67.2.2(h)(8)(C) and (h)(8)(D).)

1. **Tiered Network**

The health plan shall indicate whether the network is a tiered network, as defined. (Rule 1300.67.2.2(b)(22)(B)).

5. **Network Service Area** (Rule 1300.67.2.2(h)(8)(C))

The health plan shall specify the network service area for the reported network. Within the network access profile, the health plan shall identify all counties within the approved network service area of the identified network, including counties for which the network service area includes only a portion of the county.

6. **Source of Network Providers and Plan-to-Plan Contracts** (Rule 1300.67.2.2(h)(8)(C))

For each reported network, the health plan shall identify and provide information concerning the source of network providers, including plan-to-plan contracts that contribute network providers to the network.

* 1. Within the web portal, the health plan shall specify all the following that apply:
     1. **Network Providers are Directly Employed or Contracted with the Health Plan.** Some or all of the network providers within the identified network meet the criteria set forth in Rule 1300.67.2.2(b)(10)(B)(i)-(iii) (contracted directly with the health plan, employed by the health plan, or are available through an association, provider group or other entity that is contracted directly with the health plan).
     2. **Plan-to-Plan Contract – The plan completing this profile is a primary plan for this network.** This network has a plan-to-plan contract with at least one subcontracted plan. The identified network includes at least one network provider that is made available to the health plan’s enrollees through a plan-to-plan contract with a subcontracted plan, as defined in Rule 1300.67.2.2(b)(10)(B)(iv) and (b)(13).
     3. **Plan-to-Plan Contract – The plan completing this profile is a subcontracted plan for this network.** This network has a plan-to-plan contract with at least one primary plan. The identified network includes at least one network provider that is made available to another health plan’s network through a plan-to-plan contract with the primary plan, as defined in Rule 1300.67.2.2(b)(13).
  2. A health plan that selects “Plan-to-Plan Contract – The plan completing this profile is a primary plan for this network” shall identify all full-service and specialized subcontracted plans that contribute network providers to the network. For each subcontracted plan that contributes network providers to the network, the health plan shall identify:
     1. The name and license number of the subcontracted plan. The Department will provide an updated list of health plan names and license numbers within the web portal.
     2. Network name and network identifier of the subcontracted plan’s network that is available, in whole or in part, to the primary plan’s network. The Department will provide an updated list of network names and identifiers within the web portal.
     3. Whether the plan-to-plan contract includes a delegation of duties, or no delegation of duties:

(i) Delegation: The primary plan has delegated some or all of its health plan functions to the subcontracted plan within the scope of the subcontracted plan’s license, as allowable under the Knox-Keene Act; or

(ii) No Delegation: The subcontracted plan makes network providers available to the primary plan but the primary plan has not delegated health plan functions to the subcontracted plan.

* 1. A health plan that selects “Plan-to-Plan Contract – The plan completing this profile is a subcontracted plan for this network” shall identify all primary plans that use the health plan’s network through a plan-to-plan contract. For each primary plan that uses some or all network providers within the health plan’s network, the health plan shall identify:
     1. The name and license number of the primary plan. The Department will provide an updated list of health plan names and license numbers within the web portal.
     2. Whether all of the network providers, or only some of the network providers in the network are available to each primary plan network.
     3. Whether the plan-to-plan contract includes a delegation of duties, or no delegation of duties:

(i) Delegation: The primary plan has delegated health plan functions to the health plan within the scope of the health plan’s license, as allowable under the Knox-Keene Act; or

(ii) No Delegation: The health plan makes network providers available to the primary plan but the primary plan has not delegated health plan functions to the health plan.

7. **Report Form Identification** (Rule 1300.67.2.2(h)(2))

The health plan shall identify the title of each report form that it will submit for each reported network. Report forms that are applicable to the health plan’s reported network(s) shall be completed, uploaded and submitted to the Department within the web portal.

8. **Standardized Terminology and Crosswalk Tables** (Rule 1300.67.2.2(h)(8)(D))

The health plan shall use the Department’s standardized terminology when reporting data in the categories listed in Rules 1300.67.2.2(h)(8)(D)(i)-(x). The Department’s standardized terminology for the data listed in Rules 1300.67.2.2(h)(8)(D)(ii)-(iv), (vi), (ix), and (x) are set forth in **Appendices A-F**. The Department’s standardized terminology for the data listed in Rules 1300.67.2.2(h)(8)(D)(i), (v), (vii) and (viii) are available within the Department’s web portal. As available, health plans may use crosswalk tables provided within the network access profile of the web portal to report standardized terminology by connecting the health plan’s own terminology to the standardized terminology via the crosswalk tables. See the [Reporting with Standardized Terminology](#_Reporting_With_Standardized) section within this Manual for more information.

9. **Verification**

Prior to submission of the network access profile or report forms, the designee for the health plan responsible for reviewing and submitting the reports shall verify the accuracy and correctness of the annual submission, in accordance with Rule 1300.67.2.2(h)(2).

# General Instructions Applicable to All Required Report Forms (Rules 1300.67.2.2(h)(7))

**Attention: Review these instructions before populating any report forms for submission in the Annual Network Report.**

The general instructions below are applicable to the report forms health plans are required to submit annually as part of the Annual Network Report. (Rules 1300.67.2.2(h)(1), (2), (6) and (7).)

## Reporting Data from Subcontracted Plans

The primary plan in a plan-to-plan contract for a reported network is responsible for submitting all data for the network, as described in Rule 1300.67.2.2(h)(1)(A), including required report forms for the Annual Network Report, as described in Rule 1300.67.2.2(h)(3). Subcontracted plans are responsible for submitting the information described in Rule 1300.67.2.2(h)(1)(B). The data included in the primary plan’s submission shall represent all network providers, including those made available to the network through a plan-to-plan contract as defined in Rule 1300.67.2.2(b)(13).

## Reporting Multiple Entries for the Same Data Field

When reporting network providers within the Annual Network Report Forms the health plan shall report all responsive data for the network provider. When applicable, the health plan shall report more than one entry for the same data field (e.g., a network provider practices at multiple addresses, has multiple specialty types, or participates in multiple provider groups). To report more than one entry for the same data field for a network provider, the health plan shall create a new record (i.e., populate an additional row) for the network provider. The new record shall contain the data entered in all fields that do not vary, as well as the new entry in the data field that varies. For each network provider, the health plan shall report the number of records needed to describe all possible combinations of required data applicable to the network provider.

Examples of fields that may require multiple entries for a network provider are:

1. Specialty Type: The network provider may practice in both a specialty and a subspecialty or in multiple specialties.

2. Type of License or Certificate: The network provider may hold more than one license or certificate.

3. Practice Address: The network provider may practice at more than one address.

4. Facility Name: The network provider may hold privileges or admit patients at more than one facility.

5. Provider Group: The network provider may participate in more than one provider group.

When reporting network service area and enrollment data within the Network Service Area and Enrollment Report Form, the health plan shall report all responsive data for the network. When applicable, the health plan shall report more than one entry for the same data field, such as enrollees that are delegated to more than one subcontracted plan within the same network, product line, county and ZIP Code. To report more than one entry for the same data field, the health plan shall create a new record. The new record shall contain the new entry in the data field or fields that vary, and the health plan shall repeat the data entered in all fields that do not vary. For more information about the reporting of enrollment data, please see the instructions in the [Network Service Area and Enrollment Report Form](#_Network_Service_Area) section of this Manual.

## Reporting with Standardized Terminology (Rule 1300.67.2.2(h)(8)(D))

Health plans shall report data according to the Department’s standardized terminology, either directly within the report forms, or by associating the health plan’s own terminology to the standardized terminology by using the available crosswalk tables in the web portal. Health plans shall report the term “other” rather than using the Department’s standardized terminology, only when there is no standardized terminology that describes the data to be reported. To report “other” instead of a standardized term, the health plan shall first complete the “other” field within the applicable crosswalk table to identify the plan’s own terminology that does not meet any standardized term. Standardized terminology is described in **Appendices A-F** of this Instruction Manual, or in the web portal, as set forth in Rule 1300.67.2.2(h)(8)(D)(i)-(x). The health plan shall use the Department’s standardized terminology in the following fields within the report forms:

1. Hospital and Other Inpatient Facility Names – Health plans shall report each hospital and other inpatient facility names using the terminology made available on the web portal, as described in Rule 1300.67.2.2(h)(8)(D)(i).
2. Product Line Categories – The standardized terminology for product lines is set forth in [**Appendix A**](#_Appendix_A:_Product) of this Manual.
3. Provider Types – The standardized terminology for provider types is set forth in [**Appendix B**](#_Appendix_B:_Provider) of this Manual. The provider type terminology includes standardized terminology to describe physician and other individual provider specialties and to describe the services delivered by facility and other entity providers. Plans are required to use this terminology and may vary from the standardized terminology only when there are no standardized terms that accurately reflect the provider’s specialty or other provider type. In such cases, the plan shall report the provider type as “other” in the data submission, in accordance with the instructions in this subsection. The Provider Types Appendix includes standardized terminology for the following fields:
   1. Primary Care Physician (PCP) Specialty Type
   2. Specialist Physician Specialty Type
   3. Non-Physician Medical Practitioner (NPMP) Specialty Type
   4. Mental Health Facility Type
   5. Non-Physician Mental Health Professional Specialty Type
   6. Other Outpatient Provider Type
   7. Hospital and Other Inpatient Facility Type
   8. Clinic Type
4. Provider Languages – The standardized terminology for provider language is set forth in [**Appendix C**](#_Appendix_C:_Provider) of this Manual.
5. Provider Group Names – Health plans shall report each provider group using the terminology made available on the web portal, as described in Rule 1300.67.2.2(h)(8)(D)(v). If the provider is an individually contracted provider, the health plan shall report or crosswalk to “individually contracted provider.”
6. Type of License and Certificate – The standardized terminology for a provider’s type of license or certificate is set forth in [**Appendix D**](#_Appendix_D:_Type) of this Manual. The Type of License and Certificate Appendix includes standardized terminology for the following fields:
   1. Primary Care Physician (PCP) License Type
   2. Non-Physician Medical Practitioner (NPMP) License and Certificate Type
   3. Specialist Physician License Type
   4. Mental Health Professional (MHP) License and Certificate Type
7. ZIP Code and County – Health plans shall report each county and ZIP Code as described in Rule 1300.67.2.2(h)(8)(D)(vii) and made available on the web portal.
8. California License Number and National Provider Identifier (NPI) -- Health plans shall report each California License Number and NPI as described in Rule 1300.67.2.2(h)(8)(D)(viii). The Department shall make available annually in its web portal a current list of de-activated NPIs, based on the applicable network capture date, derived from the National Plan and Provider Enumeration System (NPPES), NPI registry.
9. Telehealth Terminology – The standardized terminology for reporting patient location type and telehealth modality data is set forth in [**Appendix E**](#_Appendix_E:_Telehealth) of this Manual, as described in Rule 1300.67.2.2(h)(8)(D)(x). The Telehealth Terminology Appendix includes standardized terminology for the following fields:
   1. Patient Location Type Category
   2. Telehealth Delivery Modality Category
10. Grievance Field Values – The standardized terminology for reporting grievance data is set forth in [**Appendix F**](#_Appendix_F:_Grievance) of this Manual. The Grievance Field Values Appendix includes standardized terminology for the following fields:
    1. Complaint Category
    2. Provider Category
    3. Nature of Resolution
    4. Resolution Determination

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# Annual Network Report Forms

Health plans that meet the description set forth in Rule 1300.67.2.2(h)(1)(A) shall submit to the Department on an annual basis, an Annual Network Report, as set forth in subsection (h)(7) of Rule 1300.67.2.2. Health plans shall complete and submit all required Annual Network Report Forms according to the instructions within this Manual and within Rule 1300.67.2.2(h)(7). All reporting plans shall submit the Network Service Area and Enrollment Report [Form](#_General_Instructions_Applicable) and all other report forms applicable to the health plan network. Review the instructions set forth below, and the [General Instructions Applicable to All Report Forms](#_General_Instructions_Applicable_1) before populating each individual Annual Network Report Form. Health plans that do not complete and submit the Annual Network Report Forms according to the instructions may receive a finding of non-compliance pursuant to Rule 1300.67.2.2(i). Annual Network Report Forms are available within the Department’s web portal.

**Department-Directed Information:**

The Department-Directed Information section is located at the end of the Provider Network Tab. Unless the Department has directed health plans to submit specific documents or information in this section, information submitted in the Department-Directed Information section is not part of the Plan’s Annual Network Report submission. Questions regarding the Annual Network Report, or responses to findings may be submitted through the Messages tab of the Timely Access and Annual Network Reporting Web Portal.

## Network Service Area and Enrollment Report Form (Form 40-265): Instructions

This report form consists of three fillable tabs: the Network Service Area Report Tab, the Primary Plan Enrollment Report Tab, and the Subcontracted Plan Enrollment Report tab. All health plans that are required to report annual network data shall complete the Network Service Area Report Tab and the Primary Plan Enrollment Report Tab, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(vi).) Additionally, primary plans that delegate some or all enrollment to a subcontracted plan via a plan-to-plan contract shall also complete the Subcontracted Plan Enrollment Report Tab. The primary plan is the reporting plan, as defined in Rule 1300.67.2.2(b)(17). See also the definitions of plan-to-plan contract and subcontracted plan in Rule 1300.67.2.2(b)(13).

1. Within the Network Service Area Report Tab, for each reported network, report all full counties or—in the case of partial counties—county and ZIP Code combinations that comprise the health plan’s network service area as of the network capture date. (Rule 1300.67.2.2(h)(7)(A)(ii).) The health plan shall report all counties and, where necessary, ZIP Codes within the network service area, regardless of whether enrollees reside or work within the ZIP Code, or whether the health plan currently offers products within the ZIP Code. Unless otherwise directed, each reported network service area shall reflect the most recently approved network service area on file with the Department in the eFile web portal pursuant to the health plan's original licensing application, or as modified by a Notice of Material Modification pursuant to Section 1352, sub. (b) and Rule 1300.52.4. Where the plan reports a network service area that differs from the approved network service area on file with the Department, the Department may presume that the network service area was reported in error.
2. Within the Primary Plan Enrollment Report Tab, for each reported network, report the count of all individuals enrolled within each ZIP Code, county, and product line as of the network capture date, in accordance with the instructions for each required field. (Rule 1300.67.2.2(h)(7)(A)(i).) The count of enrollees includes **both** the enrollees for whom the primary plan arranges care, **and** the enrollees that the primary plan has delegated to one or more subcontracted plans via a plan-to-plan contract, if applicable. When completing the Primary Plan Enrollment Report Tab, report enrollees in a county and ZIP Code based on the enrollee address that qualified the enrollee for enrollment in the network. Depending on how the enrollee became eligible for enrollment, this may be the enrollee’s personal residence, workplace address or other location. (Rule 1300.51(d)(H).)
3. Within the Subcontracted Plan Enrollment Report Tab, for each reported network, report the count of all individuals enrolled within each ZIP Code, county and product line that are **delegated** to a subcontracted plan via a plan-to-plan contract, if applicable. Report in the "Subcontracted Plan License Number" field the license number of the subcontracted plan to which the primary plan's enrollees were delegated for the applicable network, product line, county and ZIP Code. If the primary plan contracts with more than one subcontracted plan, enter a separate record for each subcontracted plan and repeat all other relevant data fields (e.g., product line, county, ZIP Code, etc.). (Rule 1300.67.2.2(h)(3).) Field instructions for this tab specify which information should be based on the primary plan and which information should be based on the subcontracted plan. When completing the Subcontracted Plan Enrollment Report Tab, report enrollees in a county and ZIP Code based on the enrollee address that qualified the enrollee for enrollment in the network. Depending on how the enrollee became eligible for enrollment, this may be the enrollee’s personal residence, workplace address or other location. (Rule 1300.51(d)(H).)

The following field instructions describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the [Definitions](#_Definitions) section of the Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the [Reporting Multiple Entries for the Same Data Field](#_Reporting_Multiple_Entries) and [Reporting with Standardized Terminology](#_Reporting_With_Standardized) subsections in the [General Instructions Applicable to All Required Report Forms](#_General_Instructions_Applicable_1) section of the Instruction Manual for more information about how to complete these fields.

**Network Service Area Report Tab**

| **FIELD NAME -**NETWORK SERVICE AREA | **FIELD INSTRUCTIONS -** NETWORK SERVICE AREAFor each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The primary plan's network name as defined in Rule 1300.67.2.2(b)(9), for the reported network service area. |
| **Network ID** | The network identifier for the primary plan’s reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Product Line** | The product line(s) using the primary plan's reported network in the reported ZIP Code and county, as set forth in **Appendix A** of the Instruction Manual. |
| **Network Service Area Information** | |
| **County** | The county or partial county within the primary plan’s network service area for the reported network. |
| **Full or Partial County** | Identify whether the plan's network service area includes the entirety of the county or only a part of the county. |
| **ZIP Code** | The ZIP Codes associated with the reported partial county within the primary plan’s network service area for the reported network. |

**Primary Plan Enrollment Report Tab**

| **FIELD NAME –**PRIMARY PLAN ENROLLMENT | **FIELD INSTRUCTIONS –**PRIMARY PLANENROLLMENT For each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The primary plan’s network name as defined in Rule 1300.67.2.2(b)(9), corresponding to the identified enrollment. |
| **Network ID** | The network identifier for the primary plan’s reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Product Line** | The product line(s) using the primary plan’s reported network, as set forth in **Appendix A** of the Instruction Manual. |
| **Network Enrollment Information** | |
| **County** | The county where identified enrollees reside or work. Report the county that qualifies an enrollee to be enrolled in the network and product line either due to a workplace address or residence address. Only report a county outside the primary plan's network service area for an enrollee if there is no qualifying county for that enrollee within the network service area. |
| **ZIP Code** | The ZIP Code within the reported county where identified enrollees reside or work. Report the ZIP Code that qualifies an enrollee to be enrolled in the network and product line either due to a workplace address or residence address. Only report a ZIP Code outside the primary plan's network service area for an enrollee if there is no qualifying ZIP Code for that enrollee within the network service area. |
| **Inside Approved Network Service Area** | Whether the enrollment reported within the county and ZIP Code is located within the primary plan's approved network service area for the identified network name. |
| **Number of Primary Plan Enrollees** | The number of primary plan enrollees. Report the sum of all individuals enrolled in the primary plan in the reported county and ZIP Code, for the identified network and product line. Report all network enrollment pertaining to the reported county, ZIP Code and product line, irrespective of whether the primary plan delivers care to these enrollees directly or delegates the enrollees to a subcontracted plan. |

**Subcontracted Plan Enrollment Report Tab**

| **FIELD NAME –**SUBCONTRACTED PLAN ENROLLMENT | **FIELD INSTRUCTIONS –**SUBCONTRACTED PLANENROLLMENT For each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name (Primary Plan)** | The primary plan's network name as defined in Rule 1300.67.2.2(b)(9), corresponding to the identified enrollment. |
| **Network ID (Primary Plan)** | The network identifier for the primary plan's reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Product Line (Primary Plan)** | The product line(s) using the primary plan's reported network, as set forth in **Appendix A** of the Instruction Manual. |
| **Network Enrollment Information** | |
| **County** | The county where identified enrollees delegated to the identified subcontracted plan reside or work. Report the county that qualifies an enrollee to be enrolled in the network and product line either due to a workplace address or residence address. Only report a county outside the primary plan's network service area for an enrollee if there is no qualifying county for that enrollee within the network service area. |
| **ZIP Code** | The ZIP Code within the reported county where identified enrollees delegated to the identified subcontracted plan reside or work. Report the ZIP Code that qualifies an enrollee to be enrolled in the primary plan network and product line either due to a workplace address or residence address. Only report a ZIP Code outside the primary plan's network service area for an enrollee if there is no qualifying ZIP Code for that enrollee within the network service area. |
| **Inside Approved Network Service Area** | Whether the county and ZIP Code where the enrollment is located is within the primary plan's approved network service area for the identified network name. |
| **Number of Subcontracted Plan Enrollees** | The number of enrollees delegated to the subcontracted plan identified in the "Subcontracted Plan License Number" and "Subcontracted Plan Network ID" fields for the identified network, product line, county and ZIP Code. |
| **Subcontracted Plan Information** | |
| **Subcontracted Plan License Number** | The License Number of the subcontracted plan with which the primary plan holds a plan-to-plan contract to delegate the delivery of services to enrollees within the primary plan's network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). |
| **Subcontracted Plan Network ID** | The network identifier of the subcontracted plan with which the primary plan holds a plan-to-plan contract to delegate the delivery of services to enrollees within the primary plan's network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). |

## PCP and PCP Non-Physician Medical Practitioner Report Form (Form No. 40-266): Instructions

This report form consists of two tabs: the Primary Care Physician (PCP) Report Tab and PCP Non-Physician Medical Practitioner (NPMP) Report Tab. All health plans that include PCPs or PCP NPMPs in the network shall complete the PCP Report Tab and PCP NPMP Report Tab, respectively, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(i).)

Only report providers who meet the definition of “network provider” on this report form. (See Rule 1300.67.2.2(b)(10).) Do not report network providers who exclusively deliver services via telehealth modalities within this report form. In addition, do not report limited plan providers within this report form. Limited plan providers must be reported within the Limited Plan Provider Report Tab on the Non-Network Provider Arrangements Report Form (Form No. 40-287).

Within the PCP Report Tab, for each reported network, report all primary care physicians as of the network capture date. (Rule 1300.67.2.2(h)(7)(A)(iii).) Only physicians may be included in this Report Tab.

Within the PCP NPMP Report Tab, for each reported network, report non-physician medical practitioners that provide primary care, as of the network capture date. Within this tab, the Plan may only report NPMPs who are supervised by a primary care physician if the primary care physician is reported on the PCP Report Tab with a valid NPI. The Plan may report NPMPs who provide primary care services and are authorized to practice independent of physician supervision or collaboration, in compliance with Chapter 6 (commencing with section 2700) of Division 2 of the Business and Professions Code.

The following field instructions describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the [Definitions](#_Definitions) section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the [Reporting Multiple Entries for the Same Data Field](#_Reporting_Multiple_Entries) and [Reporting with Standardized Terminology](#_Reporting_With_Standardized) subsections in the [General Instructions Applicable to All Required Report Forms](#_General_Instructions_Applicable_1) section of this Instruction Manual for more information about how to complete these fields.

**Primary Care Physician (PCP) Report Tab**

| **FIELD NAME *-***PCP | **FIELD INSTRUCTIONS-**PCP  For each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(9). |
| **Network ID** | The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Subcontracted Plan Information** | |
| **Subcontracted Plan License Number** | The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). Each health plan's license number is available on the Department's web portal. |
| **Subcontracted Plan Network ID** | The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan’s network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). |
| **Network Provider Information** | |
| **Last Name** | Last name of the network provider. |
| **First Name** | First name of the network provider. |
| **NPI** | The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date. |
| **CA License** | California license number of the network provider, active on the network capture date. |
| **Non-CA License** | License number issued outside of the state of California, active on the network capture date. |
| **Non-CA License State** | State in which the Non-California license was issued. |
| **License Type** | The network provider's type of license, as set forth in **Appendix D**. |
| **Number of Enrollees Assigned to Provider** | The total number of enrollees within the network assigned to the network provider, or, where enrollees are not assigned, for whom the network provider delivers primary care, as defined in section 1367.69(b). |
| **Specialty** | The network provider's specialty or subspecialty, as set forth in **Appendix B**. |
| **Population Age Served** | The enrollee population served by the network provider at the identified practice address. Indicate whether the provider serves adult enrollees (aged 18 years and older), pediatric enrollees (aged 17 years and younger), or both adult enrollees and pediatric enrollees at the practice address. |
| **Board Certified / Eligible** | For each reported specialty or subspecialty, indicate whether the network provider is board-certified or board-eligible. |
| **Provider Group** | Name of the provider group affiliated with the network provider, if applicable. |
| **Network Tier ID** | The network tier in which the network provider is available to enrollees, if the network is a tiered network. Refer to the definition of network tier in Rule 1300.67.2.2(b). |
| **Full-Time / Part-Time** | The network provider’s practice hours. Identify whether, as of the network capture date, the network provider is full-time or part-time as these terms are defined in Rule 1300.67.2.2(b). |
| **Facility** | The name of each hospital or other facility where:   * The network provider holds privileges; * The network provider uses a hospitalist or other physician arrangement to admit patients to the hospital; or * The network provider treats patients, if the provider delivers services within a facility. |
| **Facility NPI** | The NPI corresponding to the facility identified in the “Facility” field. |
| **Provider Language 1** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 2** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 3** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Network Provider Practice Location and Associated Information** | |
| **Practice Address** | The street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical location at which the network provider delivers in-person health care services. |
| **Practice Address 2** | The number of the office, suite, building or other location identifier for the practice address, if applicable. |
| **City** | City in which the practice address is located. |
| **County** | County in which the practice address is located. |
| **State** | State in which the practice address is located. |
| **ZIP Code** | ZIP Code in which the practice address is located. |
| **Phone Number** | The phone number an enrollee may use to schedule an appointment at the reported practice address, if applicable. |
| **Clinic Name** | The name of the clinic at which the network provider delivers services either part-time or full-time, if applicable. |
| **Accepting New Patients** | The availability of the network provider to accept new patients, as the term is defined Rule 1300.67.2.2(b). Identify whether the network provider is accepting new patients at the reported practice address. |
| **Displayed in Provider Directory** | The network provider’s inclusion in the health plan’s provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan’s online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this tab. |
| **In-Person Appointments** | The availability of the network provider to offer in-person appointments on an outpatient basis, as the term is defined in Rule 1300.67.2.2(b). |
| **Unscheduled Urgent Services** | The network provider’s availability to deliver unscheduled urgent services as defined in Rule 1300.67.2.2(b). Identify whether the network provider delivers unscheduled urgent services at the reported practice address. |
| **E-mail Address** | Network provider's office email address, if applicable, as set forth in section 1367.27(i)(6). |

**PCP Non-Physician Medical Practitioner (NPMP) Report Tab**

| **FIELD NAME -**PCP NPMP | **FIELD INSTRUCTIONS -**PCP NPMP  For each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(9). |
| **Network ID** | The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Subcontracted Plan Information** | |
| **Subcontracted Plan License Number** | The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). Each health plan's license number is available on the Department's web portal. |
| **Subcontracted Plan Network ID** | The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan’s network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). |
| **Network Provider Information** | |
| **Last Name** | Last name of the network provider. |
| **First Name** | First name of the network provider. |
| **NPI** | The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date. |
| **CA License** | California license number of the network provider, active on the network capture date. |
| **License Type** | The network provider's type of license, as set forth in  **Appendix D**. |
| **Population Age Served** | The enrollee population served by the network provider at the identified practice address. Indicate whether the provider serves adult enrollees (aged 18 years and older), pediatric enrollees (aged 17 years and younger), or both adult enrollees and pediatric enrollees at the practice address. |
| **Number of Enrollees Assigned to Provider** | If the NPMP serves as a PCP or otherwise independently provides direct care to enrollees, the total number of enrollees within the network assigned to the network provider, or, where enrollees are not assigned, the number of enrollees for whom the network provider delivers primary care, as defined in section 1367.69(b). |
| **NPI of Supervising PCP** | The unique National Provider Identifier (NPI) of the reported primary care physician (PCP) who supervises the non-physician medical practitioner. |
| **Provider Group** | Name of the provider group affiliated with the network provider, if applicable. |
| **Network Tier ID** | The network tier in which the network provider is available to enrollees, if the network is a tiered network. Refer to the definition of network tier in Rule 1300.67.2.2. |
| **Full-Time / Part-Time** | The network provider’s practice hours. Identify whether, as of the network capture date, the network provider is full-time or part-time as these terms are defined in Rule 1300.67.2.2(b). |
| **Provider Language 1** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 2** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 3** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Network Provider Practice Location and Associated Information** | |
| **Practice Address** | The street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical locations at which the network provider delivers in-person health care services. |
| **Practice Address 2** | The number of the office, suite, building or other location identifier for the practice address, if applicable. |
| **City** | City in which the practice address is located. |
| **County** | County in which the practice address is located. |
| **State** | State in which the practice address is located. |
| **ZIP Code** | ZIP Code in which the practice address is located. |
| **Phone Number** | The phone number an enrollee may use to schedule an appointment at the reported practice location, if applicable. |
| **Clinic Name** | The name of the clinic at which the network provider delivers services either part-time or full-time, if applicable. |
| **Accepting New Patients or Referrals** | The availability of the network provider to accept new patients, as the term is defined in Rule 1300.67.2.2(b). Identify whether the network provider is accepting new patients at the reported practice address. |
| **Displayed in Provider Directory** | The network provider’s inclusion in the health plan’s provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan’s online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form. |
| **In-Person Appointments** | The availability of the network provider to offer in-person appointments on an outpatient basis as the term is defined in Rule 1300.67.2.2(b). |
| **Unscheduled Urgent Services** | The network provider’s availability to deliver unscheduled urgent services as defined in Rule 1300.67.2.2(b). Identify whether the network provider delivers unscheduled urgent services at the reported practice address. |
| **E-mail Address** | Network provider's office email address, if applicable, as set forth in section 1367.27(i)(6). |

## Specialist and Specialist Non-Physician Medical Practitioner Report Form (Form No. 40-267): Instructions

This report form consists of two tabs: the Specialist Report Tab and the Specialist Non-Physician Medical Practitioner (NPMP) Report Tab. All health plans that include specialist physicians or specialist NPMPs in the network shall complete the Specialist Report Tab and Specialist NPMP Report Tab, respectively, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(ii).) Only report providers who meet the definition of “network provider” on this report form. (See Rule 1300.67.2.2(b)(10).) Do not report network providers who exclusively deliver services via telehealth modalities within this report form. In addition, do not report limited plan providers within this report form. Limited plan providers must be reported within the Limited Plan Provider Report Tab on the Non-Network Provider Arrangements Report Form (Form No. 40-287).

Within the Specialist Report Tab, for each reported network, report all specialist physicians as of the network capture date. (Rule 1300.67.2.2(h)(7)(A)(iii).) Only physicians may be included in this report tab. The Plan may report physicians that are qualified autism services providers (QASP), as defined in Health and Safety Code section 1374.73(c)(3), within the Specialist Report Tab. A non-physician QASP shall be reported on the Mental Health Professional and Mental Health Facility Report Form (Form No. 40-268).

Within the Specialist NPMP Report Tab, for each reported network, report non-physician medical practitioners that provide specialty care as of the network capture date. Within this tab, the Plan may only report NPMPs who are supervised by a specialist physician if the specialist physician is reported on the Specialist Report Tab with a valid NPI. The Plan may report specialist NPMPs who are authorized to practice independent of physician supervision or collaboration, in compliance with Chapter 6 (commencing with section 2700) of Division 2 of the Business and Professions Code.

The following field instructions describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the [Definitions](#_Definitions) section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the [Reporting Multiple Entries for the Same Data Field](#_Reporting_Multiple_Entries) and [Reporting with Standardized Terminology](#_Reporting_With_Standardized) subsections in the [General Instructions Applicable to All Required Report Forms](#_General_Instructions_Applicable_1) section of this Instruction Manual for more information about how to complete these fields.

**Specialist Report Tab**

| **FIELD NAME -**SPECIALIST | **FIELD INSTRUCTIONS -**SPECIALISTFor each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(9). |
| **Network ID** | The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Subcontracted Plan Information** | |
| **Subcontracted Plan License Number** | The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). Each health plan's license number is available on the Department's web portal. |
| **Subcontracted Plan Network ID** | The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan’s network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). |
| **Network Provider Information** | |
| **Last Name** | Last name of the network provider. |
| **First Name** | First name of the network provider. |
| **NPI** | The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date. |
| **CA License** | California license number of the network provider, active on the network capture date. |
| **Non-CA License** | License number issued outside of the state of California, active on the network capture date. |
| **Non-CA License State** | State in which the non-California license was issued. |
| **License Type** | The network provider's type of license, as set forth in  **Appendix D**. |
| **Specialty** | The network provider's specialty or subspecialty, as set forth in **Appendix B**. |
| **Population Age Served** | The enrollee population served by the network provider at the identified practice address. Indicate whether the provider serves adult enrollees (aged 18 years and older), pediatric enrollees (aged 17 years and younger), or both adult enrollees and pediatric enrollees at the practice address. |
| **Board Certified / Eligible** | For each reported specialty or subspecialty, indicate whether the network provider is board-certified or board-eligible. |
| **Provider Group** | Name of the provider group affiliated with the network provider, if applicable. |
| **Network Tier ID** | The network tier in which the network provider is available to enrollees, if the network is a tiered network. Refer to the definition of network tier in Rule 1300.67.2.2. |
| **Full-Time / Part-Time** | The network provider’s practice hours. Identify whether, as of the network capture date, the network provider is full-time or part-time as these terms are defined in Rule 1300.67.2.2(b). |
| **Facility** | The name of each hospital or other facility where:   * The network provider holds privileges; * The network provider uses a hospitalist or other physician arrangement to admit patients to the hospital; or * The network provider treats patients, if the provider delivers services within a facility. |
| **Facility NPI** | The NPI corresponding to the facility identified in the “Facility” field. |
| **Hospitalist** | The network provider's method of admitting patients. Identify whether the network provider admits patients to the hospital or other facility identified in the corresponding “Facility” field directly, or by using a hospitalist or some other physician arrangement. |
| **Provider Language 1** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 2** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 3** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Network Provider Practice Location and Associated Information** | |
| **Practice Address** | The street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical location at which the network provider delivers in-person health care services. |
| **Practice Address 2** | The number of the office, suite, building or other location identifier for the practice address, if applicable. |
| **City** | City in which the practice address is located. |
| **County** | County in which the practice address is located. |
| **State** | State in which the practice address is located. |
| **ZIP Code** | ZIP Code in which the practice address is located. |
| **Phone Number** | The phone number an enrollee may use to schedule an appointment at the reported practice address, if applicable. |
| **Clinic Name** | The name of the clinic at which the network provider delivers services either part-time or full-time, if applicable. |
| **Accepting New Patients or Referrals** | The availability of the network provider to accept new patients, as the term is defined in Rule 1300.67.2.2(b). Identify whether the network provider is accepting new patients at the reported practice address. |
| **Displayed in Provider Directory** | The network provider’s inclusion in the health plan’s provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan’s online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form. |
| **In-Person Appointments** | The availability of the network provider to offer in-person appointments on an outpatient basis, as the term is defined in Rule 1300.67.2.2(b). |
| **E-mail Address** | Network provider's office email address, if applicable, as set forth in section 1367.27(i)(6). |

**Specialist Non-Physician Medical Practitioner (NPMP) Report Tab**

| **FIELD NAME -**SPECIALIST NPMP | **FIELD INSTRUCTIONS -** SPECIALIST NPMPFor each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(9). |
| **Network ID** | The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Subcontracted Plan Information** | |
| **Subcontracted Plan License Number** | The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). Each health plan's license number is available on the Department's web portal. |
| **Subcontracted Plan Network ID** | The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan’s network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). |
| **Network Provider Information** | |
| **Last Name** | Last name of the network provider. |
| **First Name** | First name of the network provider. |
| **NPI** | The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date. |
| **CA License** | California license number of the network provider, active on the network capture date. |
| **License Type** | The network provider's type of license, as set forth in  **Appendix D**. |
| **Specialty** | The type of certificate or acknowledgment of special qualifications, as recognized by the National Commission on Certification of Physician Assistants and the California Board of Registered Nursing, if the network provider has earned an additional specialty certificate from the appropriate state licensing board, as set forth in **Appendix B**. |
| **Population Age Served** | The enrollee population served by the network provider at the identified practice address. Indicate whether the provider serves adult enrollees (aged 18 years and older), pediatric enrollees (aged 17 years and younger), or both adult enrollees and pediatric enrollees at the practice address. |
| **NPI of Supervising Specialist** | The unique National Provider Identifier (NPI) of the reported physician who supervises the non-physician medical practitioner. |
| **Supervising Specialist Specialty** | The supervising physician's specialty or subspecialty. |
| **Provider Group** | Name of the provider group affiliated with the network provider, if applicable. |
| **Network Tier ID** | The network tier in which the network provider is available to enrollees, if the network is a tiered network. Refer to the definition of network tier in Rule 1300.67.2.2. |
| **Full-Time / Part-Time** | The network provider’s practice hours. Identify whether, as of the network capture date, the network provider is full-time or part-time as these terms are defined in Rule 1300.67.2.2(b). |
| **Provider Language 1** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 2** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 3** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Network Provider Practice Location and Associated Information** | |
| **Practice Address** | The street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical location at which the network provider delivers in-person health care services. |
| **Practice Address 2** | The number of the office, suite, building or other location identifier for the practice address, if applicable. |
| **City** | City in which the practice address is located. |
| **County** | County in which the practice address is located. |
| **State** | State in which the practice address is located. |
| **ZIP Code** | ZIP Code in which the practice address is located. |
| **Phone Number** | The phone number an enrollee may use to schedule an appointment at the reported practice address, if applicable. |
| **Clinic Name** | The name of the clinic at which the network provider delivers services either part-time or full-time, if applicable. |
| **Accepting New Patients or Referrals** | The availability of the network provider to accept new patients, as the term is defined in Rule 1300.67.2.2(b). Identify whether the network provider is accepting new patients at the reported practice address. |
| **Displayed in Provider Directory** | The network provider’s inclusion in the health plan’s provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan’s online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form. |
| **In-Person Appointments** | The availability of the network provider to offer in-person appointments on an outpatient basis, as the term is defined in Rule 1300.67.2.2(b). |
| **E-mail Address** | Network provider's office email address, if applicable, as set forth in section 1367.27(i)(6). |

## Mental Health Professional and Mental Health Facility Report Form (Form No. 40-268): Instructions

This report form consists of two tabs: the Mental Health Professional Report Tab and the Mental Health Facility Report Tab. All health plans that include mental health professionals or mental health facilities in the network shall complete a Mental Health Professional Report Tab and Mental Health Facility Report Tab, respectively, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(v).) Only report providers who meet the definition of “network provider” on these tabs. (See Rule 1300.67.2.2(b)(10).) Do not report network providers who exclusively deliver services via telehealth modalities within this report form. In addition, do not report limited plan providers within this report form. Limited plan providers must be reported within the Limited Plan Provider Report Tab on the Non-Network Provider Arrangements Report Form (Form No. 40-287).

Within the Mental Health Professional Report Tab, for each reported network, report all non-physician mental health professionals as of the network capture date. (Rule 1300.67.2.2(h)(7)(A)(iii).) "Non-physician mental health professionals" refers to network providers who are not licensed physicians, and who deliver mental health services, including counseling services, therapy, behavioral health treatment, and substance abuse services.

Report all licensed network providers as individual providers, as defined, using the first name and last name fields. If the provider is an entity at which unlicensed individual providers are available to provide covered services, and the health plan does not have the first and last names of the unlicensed individual providers, the plan may enter the entity name in the entity name field, rather than enter each individual unlicensed provider at the entity. However, qualified autism services providers (QASP) as defined in Health and Safety Code section 1374.73(c)(3) must be reported individually with a first name and last name, regardless of the type of license or certificate held by the QASP.

Within the Mental Health Facility Report Tab, for each reported network, report all mental health facilities as of the network capture date. "Mental health facilities” refers to providers that deliver facility-based mental health treatment, not including licensed hospitals.

The following field instructions describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the [Definitions](#_Definitions) section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the [Reporting Multiple Entries for the Same Data Field](#_Reporting_Multiple_Entries) and [Reporting with Standardized Terminology](#_Reporting_With_Standardized) subsections in the [General Instructions Applicable to All Required Report Forms](#_General_Instructions_Applicable_1) section of this Instruction Manual for more information about how to complete these fields.

**Required Fields: Clinical Encounters Reporting Timeframes**

The following two required fields in the Mental Health Professional Report Tab are subject to a different data collection timeframe than the other fields collected on this report form:

* Clinical Encounters by Network Provider
* Number of Enrollees Utilizing the Network Provider

Refer to the definitions of “clinical encounters” and “clinical data capture timeframe” in the Definition section of the Instruction Manual when completing this form.

For all other fields within the Mental Health Professional and Mental Health Facility Report Form, the data reported within this report form shall continue to reflect the network capture date of January 15th of the reporting year, as required by Rule 1300.67.2.2(b)(7)(A). Only report clinical encounter data for providers that were network providers as of January 15th of the reporting year.

**Mental Health Professional Report Tab**

| **FIELD NAME -** MENTAL HEALTH PROFESSIONAL | **FIELD INSTRUCTIONS -** MENTAL HEALTH PROFESSIONALFor each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(9). |
| **Network ID** | The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Subcontracted Plan Information** | |
| **Subcontracted Plan License Number** | The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). Each health plan's license number is available on the Department's web portal. |
| **Subcontracted Plan Network ID** | The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan’s network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). |
| **Network Provider Information** | |
| **Last Name** | Last name of the network provider. |
| **First Name** | First name of the network provider. |
| **NPI** | The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date. |
| **Entity Name** | If the health plan reported an individual network provider that delivers services through an entity, report the legal name of the entity in this field. If the network provider is an entity at which unlicensed individual providers are available to provide covered services, the health plan may enter the entity as the network provider. |
| **Entity NPI** | The unique National Provider Identifier (NPI) assigned to the entity, active on the network capture date. |
| **CA License / Certificate** | California license or certificate identifier of the network provider, active on the network capture date. |
| **Non-CA License / Certificate** | License number or certificate identifier issued outside of the state of California, active on the network capture date. |
| **Non-CA License / Certificate State** | State in which the non-California license or certificate was issued. |
| **Type of License / Certificate** | The network provider’s type of license or certificate, as set forth in **Appendix D**. |
| **Specialty** | The network provider’s specialty, as set forth in  **Appendix B**. |
| **Population Age Served** | The enrollee population served by the network provider at the identified practice address. Indicate whether the provider serves adult enrollees (aged 18 years and older), pediatric enrollees (aged 17 years and younger), or both adult enrollees and pediatric enrollees at the practice address. |
| **Provider Group** | Name of the provider group affiliated with the network provider, if applicable. |
| **Clinical Encounters by Network Provider** | The number of clinical encounters the network provider had with enrollees in the network, using the clinical data capture timeframe, as defined in the Definition section of the Instruction Manual. If the network provider had no clinical encounters with enrollees in the network during the clinical data capture timeframe, enter “0.”  If there are no clinical encounters to report for the network provider during the clinical data capture timeframe, **and** the network provider was added to the network after December 31, 2024, enter “New Network Provider” in this field. |
| **Number of Enrollees Utilizing the Network Provider** | The number of enrollees in the network who had one or more clinical encounters with the network provider, using the clinical data capture timeframe, as defined in the Definition section of the Instruction Manual. If there were no enrollees who had at least one clinical encounter with the network provider during the clinical data capture timeframe, enter “0” in this field.  If there are no clinical encounters to report for the network provider during the clinical data capture timeframe, **and** the network provider was added to the network after December 31, 2024, enter “New Network Provider” in this field. |
| **Network Tier ID** | The network tier in which the network provider is available to enrollees, if the network is a tiered network. Refer to the definition of network tier in Rule 1300.67.2.2. |
| **Full-Time / Part-Time** | The network provider’s practice hours. Identify whether, as of the network capture date, the network provider is full-time or part-time as these terms are defined Rule 1300.67.2.2(b). |
| **Facility** | The name of each hospital or other facility where the network provider treats patients, if the provider delivers services within a facility. |
| **Facility NPI** | The NPI corresponding to the facility identified in the “Facility” field. |
| **Provider Language 1** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 2** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 3** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Network Provider Practice Location and Associated Information** | |
| **Practice Address** | The street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical location at which the network provider delivers in-person health care services. |
| **Practice Address 2** | The number of the office, suite, building or other location identifier for the practice address, if applicable. |
| **City** | City in which the practice address is located. |
| **County** | County in which the practice address is located. |
| **State** | State in which the practice address is located. |
| **ZIP Code** | ZIP Code in which the practice address is located. |
| **Phone Number** | The phone number an enrollee may use to schedule an appointment at the reported practice address, if applicable. |
| **Accepting New Patients or Referrals** | The availability of the network provider to accept new patients, as the term is defined in Rule 1300.67.2.2(b). Identify whether the provider is accepting new patients at the reported practice address. |
| **Displayed in Provider Directory** | The network provider’s inclusion in the health plan’s provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan’s online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form. |
| **In-Person Appointments** | The availability of the network provider to offer in-person appointments on an outpatient basis, as the term is defined in Rule 1300.67.2.2(b). |
| **E-mail Address** | Network provider's office email address, if applicable, as set forth in section 1367.27(i)(6). |

**Mental Health Facility Report Tab**

| **FIELD NAME -** MENTAL HEALTH FACILITY | **FIELD INSTRUCTIONS -** MENTAL HEALTH FACILITYFor each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The network name within which the reported facility serves as a network provider, as defined in Rule 1300.67.2.2(b)(9). |
| **Network ID** | The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Subcontracted Plan Information** | |
| **Subcontracted Plan License Number** | The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). Each health plan's license number is available on the Department's web portal. |
| **Subcontracted Plan Network ID** | The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan’s network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). |
| **Network Provider Information** | |
| **Mental Health Facility Name** | Legal name of the network provider. |
| **DBA** | "Doing-Business-As" name of network provider, if applicable. |
| **NPI** | The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date. |
| **CA License** | California license number of the network provider, active on the network capture date. |
| **Non-CA License** | License number of the network provider, issued outside of the state of California, active on the network capture date. |
| **Non-CA License State** | State in which the non-California license was issued. |
| **Mental Health Facility Type** | The type of mental health facility, as set forth in  **Appendix B**. |
| **Population Age Served** | The enrollee population served by the network provider at the identified practice address. Indicate whether the provider serves adult enrollees (aged 18 years and older), pediatric enrollees (aged 17 years and younger), or both adult enrollees and pediatric enrollees at the practice address. |
| **Network Tier ID** | The network tier in which the network provider is available to enrollees, if the network is a tiered network. Refer to the definition of network tier in Rule 1300.67.2.2. |
| **Network Provider Practice Location and Associated Information** | |
| **Practice Address** | The street number and street name of the facility practice address. |
| **Practice Address 2** | The number of the office, suite, building or other location identifier for the practice address, if applicable. |
| **City** | City in which the practice address is located. |
| **County** | County in which the practice address is located. |
| **State** | State in which the practice address is located. |
| **ZIP Code** | ZIP Code in which the practice address is located. |
| **Phone Number** | The phone number an enrollee may use to schedule an appointment at the reported practice location, if applicable. |
| **Accepting New Patients or Referrals** | The availability of the network provider to accept new patients, as the term is defined in Rule 1300.67.2.2(b. Identify whether the facility is accepting new patients at the reported practice address. |
| **Displayed in Provider Directory** | The network provider’s inclusion in the health plan’s provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan’s online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form. |

## Other Outpatient Provider Report Form (Form No. 40-269): Instructions

All health plans that include other outpatient providers not reported on any other report form shall submit an Other Outpatient Provider Report Form, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(iv).) Only report providers who meet the definition of “network provider” on this report form. (See Rule 1300.67.2.2(b)(10).) Do not report network providers who exclusively deliver services via telehealth modalities within this report form. In addition, do not report limited plan providers within this report form. Limited plan providers must be reported within the Limited Plan Provider Report Tab on the Non-Network Provider Arrangements Report Form (Form No. 40-287).

Within the Other Outpatient Provider Report Form, for each reported network, report a complete list of the health plan’s network providers that are “other outpatient providers,” as of the network capture date. (Rule 1300.67.2.2(h)(7)(A)(iii).) “Other outpatient providers” refers to non-physician individual and entity network providers that provide outpatient health care services to enrollees, when the outpatient provider has not been reported within another report form.

Report all licensed network providers as individual providers, as defined, using the first name and last name fields. If the network provider is an entity at which unlicensed individual providers are available to provide covered services, and the health plan does not have the first and last names of the unlicensed individual providers, the plan may enter the entity name in the entity name field, rather than enter each individual unlicensed provider at the entity.

If the other outpatient provider is an individual provider that is also affiliated with an entity provider, follow the instructions within the fields below for reporting data associated with the individual provider and entity providers.

The following field instructions describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the [Definitions](#_Definitions) section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the [Reporting Multiple Entries for the Same Data Field](#_Reporting_Multiple_Entries) and [Reporting with Standardized Terminology](#_Reporting_With_Standardized) subsections in the [General Instructions Applicable to All Required Report Forms](#_General_Instructions_Applicable_1) section of this Instruction Manual for more information about how to complete these fields.

**Other Outpatient Provider Report Form**

| **FIELD NAME -**OTHER OUTPATIENT PROVIDER | **FIELD INSTRUCTIONS -**OTHER OUTPATIENT PROVIDERFor each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(9). |
| **Network ID** | The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Subcontracted Plan Information** | |
| **Subcontracted Plan License Number** | The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). Each health plan's license number is available on the Department's web portal.  If no individual provider is reported in this record, complete this field if the reported entity is a network provider for the reported network as a result of a plan-to-plan contract with a subcontracted plan. |
| **Subcontracted Plan Network ID** | The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this Network Name due to a plan-to-plan contract with a subcontracted plan’s network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). |
| **Network Provider Information** | |
| **Last Name** | Last name of the network provider, if the network provider is an individual provider. |
| **First Name** | First name of the network provider, if the network provider is an individual provider. |
| **Individual NPI** | The unique National Provider Identifier (NPI) assigned to the individual network provider, active on the network capture date. |
| **CA License** | California license number for the individual network provider reported, active on the network capture date. If no individual provider is reported in this record, report the entity network provider's California license number, if applicable. |
| **Non-CA License** | License number issued outside of the state of California for the individual network provider, active on the network capture date. If no individual provider is reported in this record, report the entity network provider's non-California license number, if applicable. |
| **Non-CA License State** | State in which the non-California license was issued. |
| **Type of License / Certificate** | The network provider’s type of license or certificate. Refer to the tables set forth in **Appendix D** for appropriate standardized terminology. |
| **Provider Group** | Name of the provider group affiliated with the individual network provider, if applicable. If no individual provider is reported in this record, report the provider group affiliated with the entity network provider, if applicable. |
| **Entity Name** | If the health plan reported an individual network provider that delivers services through an entity, report the legal name of the entity in this field. If the network provider is an entity at which unlicensed individual providers are available to provide covered services, the health plan may enter the entity as the network provider. |
| **Entity DBA** | "Doing-Business-As" name of the network provider entity, if applicable. |
| **Entity NPI** | The unique National Provider Identifier (NPI) assigned to the entity network provider. If an entity network provider is reported in this record, report the NPI of the entity, active on the network capture date. |
| **Network Tier ID** | The network tier in which the network provider is available to enrollees, if the network is a tiered network. Refer to the definition of network tier in Rule 1300.67.2.2. |
| **Facility** | If the reported individual network provider delivers health care services in a facility setting, report the name of the facility. If no individual provider is reported in this record, report the name of the facility where the entity network provider delivers health care services, if the entity provider delivers health care services within a facility. |
| **Facility NPI** | The NPI corresponding to the facility identified in the “Facility” field. |
| **Provider Type** | The provider type, as set forth in **Appendix B**, that describes the individual network provider's area of practice. If no individual provider is reported in this record, report the provider type that describes the entity network provider's area of practice. |
| **Population Age Served** | The enrollee population served by the network provider at the identified practice address. Indicate whether the provider serves adult enrollees (aged 18 years and older), pediatric enrollees (aged 17 years and younger), or both adult enrollees and pediatric enrollees at the practice address. |
| **Provider Language 1** | Language spoken by the individual network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 2** | Language spoken by the individual network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 3** | Language spoken by the individual network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Network Provider Practice Location and Associated Information** | |
| **Practice Address** | The street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical location at which the network provider delivers in-person health care services. |
| **Practice Address 2** | The number of the office, suite, building or other location identifier for the practice address, if applicable. |
| **City** | City in which the practice address is located. |
| **County** | County in which the practice address is located. |
| **State** | State in which the practice address is located. |
| **ZIP Code** | ZIP Code in which the practice address is located. |
| **Phone Number** | The phone number an enrollee may use to schedule an appointment with the individual network provider at the reported practice address, if applicable. If no individual provider is reported in this record, report the phone number an enrollee may use to schedule an appointment with the entity network provider at the reported practice address, if applicable. |
| **Accepting New Patients** | The availability of the individual network provider to accept new patients or referrals, as the term is defined in Rule 1300.67.2.2(b). Identify whether the network provider is accepting new patients at the reported practice address. If no individual provider is reported within this record, identify whether the entity network provider is accepting new patients at the reported practice address. |
| **Displayed in Provider Directory** | The individual network provider’s inclusion in the health plan’s provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan’s online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network and practice location, and the specialty or subspecialty type identified in the corresponding fields of this report form.  If no individual provider is reported in this record, identify this information for the reported entity network provider. |
| **In-Person Appointments** | The availability of the network provider to offer in-person appointments on an outpatient basis, as the term is defined in Rule 1300.67.2.2(b). |
| **Unscheduled Urgent Services** | The network provider’s availability to deliver unscheduled urgent services, as defined Rule 1300.67.2.2(b). Identify whether the individual network provider delivers unscheduled urgent services at the reported practice address. If no individual provider is reported within this record, report the availability of the entity network provider to deliver unscheduled urgent services at the reported practice address. |
| **E-mail Address** | The individual network provider's office email address, if applicable, as set forth in section 1367.27(i)(6). If no individual provider is reported in this record, report the entity network provider's office email address, if applicable. |

## Hospital and Clinic Report Form (Form No. 40-270): Instructions

This report form consists of two tabs: the Hospital Report Tab and the Clinic Report Tab. All health plans that include hospital and clinic providers in the network shall complete a Hospital Report Tab and Clinic Report Tab, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(iii).) Only report providers who meet the definition of “network provider.” (See Rule 1300.67.2.2(b)(10).) Do not report network providers who exclusively deliver services via telehealth modalities within this report form. In addition, do not report limited plan providers within this report form. Limited plan providers must be reported within the Limited Plan Provider Report Tab on the Non-Network Provider Arrangements Report Form (Form No. 40-287).

Within the Hospital Report Tab, for each reported network, report all hospitals as of the network capture date. (Rule 1300.67.2.2(h)(7)(A)(iii).) “Hospital” refers to general acute care hospitals, psychiatric hospitals, and other inpatient medical facilities. Do not include mental health facilities that are not hospitals on this report form. For a list of the standardized hospital types for this form, refer to the standardized terminology table for “hospitals and other inpatient facility types” within **Appendix B**.

Within the Clinic Report Tab, for each reported network, report all clinics as of the network capture date. “Clinics” refers to those providers that meet the definition set forth in section 1200(a). For a list of the standardized clinic types for this form, refer to the standardized terminology table for “clinic types” within **Appendix B**.

The following field instructions describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the [Definitions](#_Definitions) section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the [Reporting Multiple Entries for the Same Data Field](#_Reporting_Multiple_Entries) and [Reporting with Standardized Terminology](#_Reporting_With_Standardized) subsections in the [General Instructions Applicable to All Required Report Forms](#_General_Instructions_Applicable_1) section of this Instruction Manual for more information about how to complete these fields.

**Hospital Report Tab**

| **FIELD NAME -**HOSPITAL | **FIELD INSTRUCTIONS -** HOSPITAL For each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The network name within which the reported hospital serves as a network provider, as defined in Rule 1300.67.2.2(b)(9). |
| **Network ID** | The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Subcontracted Plan Information** | |
| **Subcontracted Plan License Number** | The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). Each health plan's license number is available on the Department's web portal. |
| **Subcontracted Plan Network ID** | The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan’s network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). |
| **Network Provider Information** | |
| **Hospital Name** | Legal name of the network provider. |
| **DBA** | "Doing-Business-As" name of hospital network provider, if applicable. |
| **NPI** | The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date. |
| **CA License** | California license number of the network provider, active on the network capture date. |
| **Non-CA License** | License number of the network provider, issued outside of the state of California, active on the network capture date. |
| **Non-CA License State** | State in which the non-California license was issued. |
| **HCAI ID** | The unique identifier established by the California Department of Health Care Access and Information (HCAI) identifying facilities used in the Licensed Facility Information System (LFIS). |
| **Hospital Type** | The type of hospital or inpatient facility, as set forth in **Appendix B**. |
| **Population Age Served** | The enrollee population served by the network provider at the identified practice address. Indicate whether the provider serves adult enrollees (aged 18 years and older), pediatric enrollees (aged 17 years and younger), or both adult enrollees and pediatric enrollees at the practice address. |
| **Network Tier ID** | The network tier, as the term is defined, in which the network provider is available to enrollees, if the network is a tiered network. |
| **Hospital System** | Name of hospital system to which the network provider belongs, if applicable. |
| **Network Provider Practice Location and Associated Information** | |
| **Practice Address** | The street number and street name of the hospital practice address. |
| **Practice Address 2** | The number of the office, suite, building or other location identifier for the practice address, if applicable. |
| **City** | City in which the practice address is located. |
| **County** | County in which the practice address is located. |
| **State** | State in which the practice address is located. |
| **ZIP Code** | ZIP Code in which the practice address is located. |
| **Type of Care** | For a general acute care hospital, identify whether the hospital is a network provider for basic hospital services, one or more particularized hospital service(s), as defined; or both at the identified practice address. |
| **Displayed in Provider Directory** | The network provider’s inclusion in the health plan’s provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan’s online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form. |

**Clinic Report Tab**

| **FIELD NAME -**CLINIC | **FIELD INSTRUCTIONS *-*** CLINIC For each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The network name within which the reported clinic serves as a network provider, as defined in Rule 1300.67.2.2(b)(9). |
| **Network ID** | The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Subcontracted Plan Information** | |
| **Subcontracted Plan License Number** | The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). Each health plan's license number is available on the Department's web portal. |
| **Subcontracted Plan Network ID** | The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan’s network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). |
| **Network Provider Information** | |
| **Clinic Name** | Legal name of the network provider. |
| **DBA** | "Doing-Business-As" name of network provider, if applicable. |
| **NPI** | The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date. |
| **CA License** | California license number of the network provider, active on the network capture date. |
| **Non-CA License** | License number issued outside of the state of California, active on the network capture date. |
| **Non-CA License State** | State in which the non-California license was issued. |
| **Clinic Type** | The type of clinic, as set forth in **Appendix B**. |
| **Population Age Served** | The enrollee population served by the network provider at the identified practice address. Indicate whether the provider serves adult enrollees (aged 18 years and older), pediatric enrollees (aged 17 years and younger), or both adult enrollees and pediatric enrollees at the practice address. |
| **Number of Enrollees Assigned to Provider** | The total number of enrollees within the network assigned to the network provider, or, where enrollees are not assigned, for whom the clinic network provider delivers primary care, as defined in section 1367.69(b). |
| **Network Tier ID** | The network tier in which the network provider is available to enrollees, if the network is a tiered network. Refer to the definition of network tier in Rule 1300.67.2.2. |
| **Network Provider Practice Location and Associated Information** | |
| **Practice Address** | The street number and street name of the clinic practice address. |
| **Practice Address 2** | The number of the office, suite, building or other location identifier for the practice address, if applicable. |
| **City** | City in which the practice address is located. |
| **County** | County in which the practice address is located. |
| **State** | State in which the practice address is located. |
| **ZIP Code** | ZIP Code in which the practice address is located. |
| **Phone Number** | The phone number an enrollee may use to schedule an appointment at the reported practice address, if applicable. |
| **Accepting New Patients** | The availability of the network provider to accept new patients, as the term is defined in Rule 1300.67.2.2(b). Identify whether the clinic is accepting new patients at the reported practice address. |
| **Displayed in Provider Directory** | The network provider’s inclusion in the health plan’s provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan’s online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form. |
| **Unscheduled Urgent Services** | The network provider’s availability to deliver unscheduled urgent services, as defined in Rule 1300.67.2.2(b). Identify whether the clinic delivers unscheduled urgent services at the reported practice address. |

## Telehealth Report Form (Form No. 40-271): Instructions

All health plans that include network providers who deliver services via telehealth modalities shall submit a Telehealth Report Form, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(vii).) Report network providers who deliver **both** in-person and telehealth services and also report network providers who deliver services **only** via telehealth modalities. Please note that health plans are required to cover services delivered through telehealth on the same basis and to the same extent that the health plan is responsible for the same service delivered through in-person treatment. (Section 1374.14(b)(1)) If the health plan does **not** submit the Telehealth Report Form, the health plan must provide an explanation in the corresponding section of the Network Access Profile explaining why the health plan did not submit the form.

Within the Telehealth Report Form, for each reported network, report a complete list of the health plan’s network providers who deliver primary care, specialty care, mental health and other outpatient provider services via telehealth modalities, as of the network capture date. (Rule 1300.67.2.2(h)(7)(A)(iii).) The health plan shall report all network providers who deliver some or all services via a defined telehealth modality. Network providers who deliver services via a telehealth modality and in-person shall be reported in the Telehealth Report Form and in the Annual Network Report Form designated for their area of practice. Network providers who exclusively deliver telehealth services shall be reported only in the Telehealth Report Form.

Report all licensed network providers as individual providers, as defined, using the first name and last name fields. If the network provider is an entity at which unlicensed individual providers are available to provide covered services, and the health plan does not have the first and last names of the unlicensed individual providers, the plan may enter the entity name in the entity name field, rather than enter each individual unlicensed provider at the entity.

The following field instructions describe the data that the reporting health plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the [Definitions](#_Definitions) section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the [Reporting Multiple Entries for the Same Data Field](#_Reporting_Multiple_Entries) and [Reporting with Standardized Terminology](#_Reporting_With_Standardized) subsections in the [General Instructions Applicable to All Required Report Forms](#_General_Instructions_Applicable_1) section of this Instruction Manual for more information about how to complete these fields.

**Report Only Telehealth Providers that are Network Providers:**

This Telehealth Report Form (Form No. 40-271) is required for the reporting of telehealth providers who are network providers, as defined in Rule 1300.67.2.2(b)(10).

**Do not report Third-Party Corporate Telehealth Providers in this Report Form:**

In accordance with Section 1374.141, as added on October 1, 2021, by assembly bill (AB) 457, the Department issued a separate report form for third-party corporate telehealth providers, as defined in Section 1374.141 (b). If the telehealth provider is a third-party corporate telehealth provider, as defined in Section 1374.141 (b), the Plan is required to report the provider on the new form, entitled Third-Party Corporate Telehealth Report Form.

If the telehealth provider is a contracting individual health professional, as defined in Section 1374.141(b), the Plan is required to report the provider as a network provider on the Telehealth Report Form (Form No. 40-271).

**Required Fields: Clinical Encounters Reporting Timeframes**

The Department includes the following two required fields in the Telehealth Report Tab, pertaining to counseling non-physician mental health professionals, in furtherance of the obligation to develop methodologies for reporting to demonstrate compliance with Section 1367.03 and supporting regulation:

• Clinical Encounters by Network Provider  
• Number of Enrollees Utilizing the Network Provider

See the definitions of “clinical encounters” and “clinical data capture timeframe” in the Definition section of the Instruction Manual when completing this form.

For all other fields within the Telehealth Report Form, the data reported within this report form shall continue to reflect the network capture date of January 15th of the reporting year as required by Rule 1300.67.2.2(b)(7)(A). If the plan has clinical encounter data for network providers who provide counseling non-physician mental health services via telehealth modalities that were not network providers as of January 15th, the plan does not report these providers within this form.

**Telehealth Report Form**

| **FIELD NAME -** TELEHEALTH | **FIELD INSTRUCTIONS -** TELEHEALTH For each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(9). |
| **Network ID** | The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Subcontracted Plan Information** | |
| **Subcontracted Plan License Number** | The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). Each health plan's license number is available on the Department's web portal. |
| **Subcontracted Plan Network ID** | The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan’s network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). |
| **Network Provider Information** | |
| **Last Name** | Last name of the network provider. |
| **First Name** | First name of the network provider. |
| **Entity Name** | If the health plan reported an individual network provider that delivers services through an entity, report the legal name of the entity name in this field. If the network provider is an entity at which unlicensed individual providers are available to provide covered services, the health plan may enter the entity as the network provider. |
| **NPI** | The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date. |
| **Network Tier ID** | The network tier in which the network provider is available to enrollees, if the network is a tiered network. Refer to the definition of network tier in Rule 1300.67.2.2. |
| **CA License / Certificate** | California license or certificate identifier of the network provider, active on the network capture date. |
| **Non-CA License / Certificate** | License number or certificate identifier issued outside of the state of California, active on the network capture date. |
| **Non-CA License / Certificate State** | State in which the non-California license or certificate was issued. |
| **Provider Type Category** | The category of provider type that corresponds to the specialty reported in the “Specialty” field. **Appendix B** sets forth the provider type categories, in the title of each specialty table. Select among the following categories:  Primary Care Physician: enter “**PCP**”  Specialist Physician: enter “**Specialist**”  Primary Care Non-Physician Medical Practitioner: enter “**PCP NPMP**”  Specialist Non-Physician Medical Practitioner: enter “**Specialist NPMP**”  Non-Physician Mental Health Professional: enter “**MHP**”  Other Outpatient Provider: enter “**OOP**”  Mental Health Facility: enter “**MHF**”  Clinic: enter “**Clinic**” |
| **Type of License / Certificate** | The network provider’s type of license or certificate, as set forth in **Appendix D**. |
| **Specialty** | The network provider’s specialty, subspecialty, or area of expertise, as set forth in **Appendix B**. |
| **Population Age Served** | The enrollee population served by the network provider at the identified practice address. Indicate whether the provider serves adult enrollees (aged 18 years and older), pediatric enrollees (aged 17 years and younger), or both adult enrollees and pediatric enrollees at the practice address. |
| **Board Certified / Eligible** | For each reported specialty or subspecialty, indicate whether the network provider is board-certified or board-eligible. |
| **Provider Group** | Name of the provider group affiliated with the network provider, if applicable. |
| **Clinical Encounters by Network Provider** | The number of clinical encounters the network provider had with enrollees in the network, using the clinical data capture timeframe, as defined. If the network provider had no clinical encounters with enrollees in the network during the clinical data capture timeframe, enter “0.”  If there are no clinical encounters to report for the network provider during the clinical data capture timeframe, **and** the network provider was added to the network after December 31, 2024, enter “New Network Provider” in this field.  This is a required field for the following network provider types:   * Licensed Clinical Social Worker; * Licensed Marriage and Family Therapist; * Licensed Professional Clinical Counselor; and * Psychologist.   If the reported provider also offers in-person appointments and the provider’s clinical encounters are reported on the Mental Health Professional and Mental Health Facility Report Form, the plan does not need to complete this field. |
| **Number of Enrollees Utilizing the Network Provider** | The number of enrollees in the network who had one or more clinical encounters with the network provider, using the clinical data capture timeframe, as defined. If there were no enrollees who had at least one clinical encounter with the network provider during the clinical data capture timeframe, enter “0” in this field.  If there are no clinical encounters to report for the network provider during the clinical data capture timeframe, and the network provider was added to the network after December 31, 2024, enter “New Network Provider” in this field.  This is a required field for the following network provider types:   * Licensed Clinical Social Worker; * Licensed Marriage and Family Therapist; * Licensed Professional Clinical Counselor; and * Psychologist.   If the reported provider also offers in-person appointments and the provider’s clinical encounters are reported on the Mental Health Professional and Mental Health Facility Report Form, the plan does not need to complete this field. |
| **Provider Language 1** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 2** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 3** | Language spoken by the network provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Network Provider Distant Site Location and Associated Information** | |
| **County** | County in which the network provider’s distant site is located. The distant site is the location where the network provider is located when delivering telehealth services, as set forth in Business and Professions Code section 2290.5(a)(2). |
| **State** | State in which the network provider’s distant site is located. The distant site is the location where the network provider is located when delivering telehealth services, as set forth in Business and Professions Code section 2290.5(a)(2). |
| **Number of Providers at Entity** | If the health plan reported network provider information by “Entity Name,” the number of network providers within the entity who provide telehealth services, for each specialty type reported. |
| **Displayed in Provider Directory** | The network provider’s inclusion in the health plan’s provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan’s online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network and specialty identified in the corresponding fields of this report form. |
| **In-Person Appointments** | Identify whether the network provider also treats patients in-person, or only treats patients via a telehealth modality. |
| **Telehealth Delivery System** | |
| **Telehealth Delivery Modality** | The telehealth modality used by the network provider to deliver telehealth services, as set forth in **Appendix E**. |
| **Patient Location** | The location type where an enrollee may receive telehealth services, as set forth in **Appendix E**, if the network provider is available for synchronous interactions with the enrollee. |

## Timely Access and Network Adequacy Grievance Report Form (Form No. 40-272): Instructions

All health plans that are required to report annual network data shall submit a Timely Access and Network Adequacy Grievance Report Form, as applicable, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(viii).)

Within the Timely Access and Network Adequacy Grievance Report Form, for each reported network, report all timely access and network adequacy grievances received during the timely access compliance measurement year, as defined in Rule 1300.67.2.2(b)(4)(A). This includes all standard, exempt, and expedited grievances received directly by the primary plan, by the subcontracted plan, or through a contracted provider group or other entity. (Rule 1300.67.2.2(h)(7)(A)(iv) and (h)(7)(B)(viii).) If the reporting plan contracts with a subcontracted plan or a non-plan entity to handle any of its grievances (e.g., provider group, or other health services management company), the reporting plan shall report all grievances lodged by primary plan enrollees with the subcontracted plan or non-plan entity.

The instructions below describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). [Refer to the Definitions](#_Definitions) section of this Instruction Manual for additional explanation of the terms used in the instructions below. Refer to the [Reporting Multiple Entries for the Same Data Field](#_Reporting_Multiple_Entries) and [Reporting with Standardized Terminology](#_Reporting_With_Standardized) subsections in the [General Instructions Applicable to All Required Report Forms](#_General_Instructions_Applicable_1) section of this Instruction Manual for more information about how to complete these fields.

**Timely Access and Network Adequacy Grievance Report Form**

| **FIELD NAME –** GRIEVANCE | **FIELD INSTRUCTIONS -**GRIEVANCE For each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The network name within which the enrollee was enrolled on the date of the grievance, as defined in Rule 1300.67.2.2(b)(9). |
| **Network ID** | The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Product Line** | The product line within which the enrollee was enrolled, as set forth in **Appendix A**, on the date of the grievance. |
| **Subcontracted Plan Information** | |
| **Subcontracted Plan License Number** | The subcontracted plan license number. Complete this field if the reporting plan has a plan-to-plan contract with a subcontracted plan for the delivery of services to enrollees within the network, and the grievance concerns a network provider or providers available through the subcontracted plan’s network, as described in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). Each health plan's license number is available in the Department's web portal. |
| **Subcontracted Plan Network ID** | The subcontracted plan network identifier. Complete this field if the reporting plan has a plan-to-plan contract with the subcontracted plan’s network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13), and the grievance concerns a network provider or providers available through the subcontracted plan’s network. |
| **Grievance Information** | |
| **Date Received** | The date the health plan received the grievance. |
| **Date Resolved** | The date the health plan resolved the grievance. |
| **Grievance Type** | The type of grievance based on the notice and resolution timeframes required under the Knox-Keene Act. Grievances shall be categorized as "Expedited," "Exempt" or "Standard," as set forth in Rule 1300.68(d) and Rule 1300.68.01. |
| **Complaint ID** | The reporting plan’s unique identifier for the grievance, or if the complaint was lodged with a subcontracted plan, the unique identifier assigned by the subcontracted plan. |
| **County** | The county where the enrollee resides or works. |
| **Provider Group** | If the provider that is the subject of the complaint is affiliated with a provider group, and the enrollee was assigned to that provider group at the time of the complaint, the name of the provider group. |
| **Complaint Category** | The category of timely access or network adequacy grievance, as defined in the [Definitions](#_Definitions) section of this Manual. See **Appendix F** for the list of complaint categories. |
| **Provider Category** | The category of network provider that is the subject of the complaint. See **Appendix F** for the list of provider categories. When there is no network provider that is the subject of the complaint, the plan may enter “plan” or “provider group” if either is the subject of the complaint. |
| **Specialty** | The specialty of the network provider who is the subject of the complaint. The entry shall reflect the provider’s specialty as of the date of the grievance. See **Appendix B** for the list of provider types and specialties. |
| **Type of License / Certificate** | The license or certificate type of the network provider who is the subject of the complaint, if the network provider is a non-physician mental health professional. The entry shall reflect the provider’s license or certificate type as of the date of the grievance. See **Appendix D** for the list of provider license or certificate types. |
| **Nature of Resolution** | The nature of the resolution for this grievance, as defined in the [Definitions](#_Definitions) section of this Manual. See **Appendix F** for a list of resolutions. |
| **Resolution Determination** | The resolution determination for this grievance, as defined in the [Definitions](#_Definitions) section of this Manual. See **Appendix F** for the list of resolution determinations. |

## Out-of-Network Payment Report Form (Form No. 40-273): Instructions

This report form consists of two tabs: the Out-of-Network Payment Report Tab and the Proportion Report Tab. All health plans that are required to report annual network data shall complete an Out-of-Network Report Tab and Proportion Report Tab, if applicable, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(C).)

Within the Out-of-Network Payment Report Tab, for each reported network, report all payments made to non-contracted providers who performed services for the health plan's enrollees at a contracting facility. (Section 1371.31(a)(4).) The Out-of-Network Payment Report Tab shall contain all payments made to non-contracted providers during the measurement year that precedes the reporting year, as set forth in Rule 1300.67.2.2(h)(7)(C), and shall include payments made by the reporting plan, by any subcontracted plan that has been delegated health plan functions for the reporting plan’s enrollees pursuant to a plan-to-plan contract, and by any contracted entity the health care service plan delegates the responsibility for payment of claims.

Within the Proportion Report Tab, for each reported network, report the proportion of contracted to non-contracted providers at the health plan’s contracting facilities. (Section 1371.31(a)(4).) The Proportion Report Tab shall include all contracting facilities in the health plan's network on the network capture date of the reporting year, regardless of whether a non-contracted provider delivered services at that facility. Report all contracting facilities that qualify as a network provider, including those that are contributed to the network by a subcontracted plan pursuant to a plan-to-plan contract. Please ensure all facilities the health plan reported on the Hospital and Clinic Report Form, Mental Health Facility Report Form, and Other Outpatient Provider Report Form are included in the Proportion Report Tab. The applicable appendices have been copied into a Standardized Terminology tab of this Report Form.

The following field instructions describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the [Definitions](#_Definitions) section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the [Reporting Multiple Entries for the Same Data Field](#_Reporting_Multiple_Entries) and [Reporting with Standardized Terminology](#_Reporting_With_Standardized) subsections in the [General Instructions Applicable to All Required Report Forms](#_General_Instructions_Applicable_1) section of this Instruction Manual for more information about how to complete these fields.

**Out-of-Network Payment Report Tab**

| **FIELD NAME *–***OUT-OF-NETWORK PAYMENT | **FIELD INSTRUCTIONS -** OUT-OF-NETWORK PAYMENT For each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The network name within which the reported contracting facility participates, as defined in Rule 1300.67.2.2(b)(9). |
| **Network ID** | The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Subcontracted Plan Information** | |
| **Subcontracted Plan License Number** | The subcontracted plan license number. Complete this field if the reporting plan has a plan-to-plan contract with a subcontracted plan for the delivery of services to enrollees within the network, as described in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13), and the out-of-network payment was made by the subcontracted plan when arranging services for the reporting plan’s enrollee. Each health plan's license number is available in the Department's web portal. |
| **Subcontracted Plan Network ID** | The subcontracted plan network identifier. Complete this field if the reporting plan has a plan-to-plan contract with the subcontracted plan’s network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13), and the out-of-network payment was made by the subcontracted plan when arranging services for the reporting plan’s enrollee. |
| **Non-Contracted Provider Information** | |
| **Non-Contracted Provider Last Name** | Last name of the non-contracted provider paid for delivering services to an enrollee at the contracting facility. |
| **Non-Contracted Provider First Name** | First name of the non-contracted provider paid for delivering services to an enrollee at the contracting facility. |
| **Non-Contracted Provider NPI** | The unique National Provider Identifier (NPI) assigned to the non-contracted provider paid for delivering services to an enrollee at the contracting facility. |
| **Contracting Facility Information** | |
| **Contracting Facility Name** | The name of the contracting facility where the non-contracted provider delivered services to an enrollee. |
| **Number of Payments Made at Contracting Facility** | The number of payments made to the non-contracted provider for delivering services to an enrollee in the identified network at the contracting facility during the reporting period. |

**Proportion Report Tab**

| **FIELD NAME -**PROPORTION | **FIELD INSTRUCTIONS** ***-***PROPORTIONFor each required field, enter the following data: |
| --- | --- |
| **Contracting Facility Information** | |
| **Contracting Facility Name** | The name of the facility that is contracted with the health plan as of the network capture date. |
| **Number of Non- Contracted Providers at Facility** | The number of unique non-contracted providers paid by the reporting plan or a subcontracted plan for rendering services to the reporting plan’s enrollees at the contracting facility during the reporting period. |
| **Number of Contracted Providers at Facility** | The number of unique contracted providers that were available to deliver services as in-network or "participating" providers at the contracting facility at any point during the measurement year, as defined in Rule 1300.67.2.2(b)(4)(A). If the reporting plan obtains network providers through a plan-to-plan contract, include all network providers made available to the reporting plan’s enrollees via the subcontracted plan. |
| **Proportion of Non-Contracted to Contracted Providers** | The Number of Non-Contracted Providers at Facility to the Number of Contracted Providers at Facility, reported in the following format:  Number of Non-Contracted Providers at Facility: Number of Contracted Providers at Facility |

## Third-Party Corporate Telehealth Provider Report Form (Form No. 40-274): Instructions

This report form consists of two tabs: the Third-Party Corporate Telehealth Provider (CTP) Data Report Tab and the Third-Party CTP Utilization Report Tab. All fields within both tabs of this report form are required, in accordance with Section 1374.141(d) and the Department’s All Plan Letters. Please refer to Section 1374.141(b) for applicable definitions, including the definition of third-party corporate telehealth provider as well as contracting individual health professional.

The field instructions below describe the data that the reporting plan shall report within each field of the report form. A reporting plan shall submit the report form on behalf of itself and on behalf of a subcontracted plan through a plan-to-plan contract, as applicable.

Refer to the [Definitions](#_Definitions) section of the Instruction Manual for defined terms used within the field instructions for this report form. Refer to the [Reporting Multiple Entries for the Same Data Field](#_Reporting_Multiple_Entries) and [Reporting with Standardized Terminology](#_Reporting_With_Standardized) subsections in the [General Instructions Applicable to All Required Report Forms](#_General_Instructions_Applicable_1) section of the Instruction Manual for more information about how to complete these fields. Refer to the applicable [Standardized Terminology Appendix](#_Standardized_Terminology_Appendices) of the Instruction Manual when the field instructions require reporting according to standardized terms within the applicable Appendix. The applicable appendices have been copied into a Standardized Terminology tab of this Report Form.

**Network Capture Timeframes**:

* The data reported within the “Third-Party CTP Data” tab of this report form shall reflect data pertaining to the third-party corporate telehealth providers contracted with the health plan as of the network capture date of January 15 of the reporting year. (Rule 1300.67.2.2(b)(5)(A).) Any field requesting data related to **clinical encounters** within the Third-Party CTP Data tab shall reflect the data collected over the course of the clinical data capture timeframe, as described below.
* The data reported within the “Third-Party CTP Utilization” tab shall **not** be reported according to the network capture date. Instead, data reported in the Third-Party CTP Utilization tab shall reflect data collected over the course of the clinical data capture timeframe, as described below.

Refer to the definitions of “clinical encounters” and “clinical data capture timeframe” in the Definition section of the Instruction Manual when completing this form.

**Third-Party CTP Data Report Tab**

| **FIELD NAME -** THIRD-PARTY CTP DATA | **FIELD INSTRUCTIONS -** THIRD-PARTY CTP DATA For each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The name of the network to which enrollees who may access the third-party corporate telehealth provider are assigned. |
| **Network ID** | The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Provider and Associated Information** | |
| **Third-Party Corporate Telehealth Provider Name** | Legal name of the third-party corporate telehealth provider or providers available on the applicable network capture date. |
| **Product Line** | The product line or product lines within the reported network, as set forth in **Appendix A**, that correspond to the reported third-party corporate telehealth provider. |
| **Specialty** | The specialty, or specialties available through the reported third-party corporate telehealth provider. Enter a new row for each applicable specialty. Data for all other fields must be included in each row.  Report the applicable specialty or subspecialty, as set forth in the tables in **Appendix B**. When reporting a non-physician mental health professional (MHP) specialty, report the type of license or certificate in this field, as set forth in the MHP table in **Appendix D**.  The specialty reported should correspond to the Provider Type Category under which the specialty is classified in **Appendices B** and **D**, and as reported in the “Provider Type Category” field. |
| **Provider Type Category** | The category of provider type that corresponds to the specialty reported in the “Specialty” field. **Appendix B** sets forth the provider type categories, in the title of each specialty table. Select among the following categories:  Primary Care Physician: enter “**PCP**”  Specialist Physician: enter “**Specialist**”  Primary Care Non-Physician Medical Practitioner: enter “**PCP NPMP**”  Specialist Non-Physician Medical Practitioner: enter “**Specialist NPMP**”  Non-Physician Mental Health Professional: enter “**MHP**”  Other Outpatient Provider: enter “**OOP**”  Mental Health Facility: enter “**MHF**”  Clinic: enter “**Clinic**” |
| **Number of Providers for Each Specialty** | The number of providers available through the reported third-party corporate telehealth provider, for the specialty reported in the “Specialty” field.  When reporting a non-physician mental health professional (MHP) specialty, report the number of providers available through the third-party corporate telehealth provider for the type of license or certificate reported in the “Specialty” field. |
| **Percentage Available as Individually Contracted Provider** | The percentage of providers reported within the “Specialty” field for the reported third-party corporate telehealth provider that are also available to enrollees as contracting individual health professionals, contracting clinics, or contracting health facilities. |
| **Count of Enrollees** | The total number of enrollees in the network and product line who are provided the option to use the third-party corporate telehealth provider's services. For third-party corporate telehealth providers that offer more than one specialty resulting in multiple entries in the “Specialty” field, repeat the total number of health plan enrollees for each row.  Include both the enrollees for whom the reporting health plan arranges care, and the enrollees that the reporting plan has delegated to one or more subcontracted plans, as applicable. |
| **Total Number of Services Delivered** | The number of clinical encounters in each network and product line, for each reported specialty available through the reported third-party corporate telehealth provider.  Data in this field should reflect clinical encounters identified by the health plan during the clinical data capture timeframe, as defined in the Definitions section of the Instruction Manual.  If there are no clinical encounters to report for the specialty during the clinical data capture timeframe, **and** the third-party corporate telehealth provider became available to enrollees after December 31, 2024, enter “**New Specialty**” in this field. |

**Third-Party CTP Utilization Report Tab**

| **FIELD NAME -** THIRD-PARTY CTP UTILIZATION | **FIELD INSTRUCTIONS -** THIRD-PARTY CTP UTILIZATION For each required field, enter the following data**:** |
| --- | --- |
| **Enrollee Information – By Specialty Type** | |
| **Specialty** | The specialty, or specialties available through the third-party corporate telehealth provider. Report only the specialty types that had clinical encounters with enrollees within the clinical data capture timeframe. Enter a new row for each applicable specialty. Data for all other fields must be included in each row.  Report the applicable specialty or subspecialty, as set forth within the tables in **Appendix B**. When reporting a non-physician mental health professional (MHP) specialty, report the type of license or certificate in this field, as set forth in the MHP table in **Appendix D**.  The specialty reported should correspond to the Provider Type Category under which the specialty is classified in **Appendices B** and **D**, and as reported in the “Provider Type Category” field.  Report data according to the definition for clinical encounters, and the definition for the clinical data capture timeframe, as set forth in the Definition section of the Instruction Manual. |
| **Provider Type Category** | The category of provider type that corresponds to the specialty reported in the “Specialty” field. **Appendix B** sets forth the provider type categories, in the title of each specialty table. Select among the following categories:  Primary Care Physician: enter “**PCP**”  Specialist Physician: enter “**Specialist**”  Primary Care Non-Physician Medical Practitioner: enter “**PCP NPMP**”  Specialist Non-Physician Medical Practitioner: enter “**Specialist NPMP**”  Non-Physician Mental Health Professional: enter “**MHP**”  Other Outpatient Provider: enter “**OOP**”  Mental Health Facility: enter “**MHF**”  Clinic: enter “**Clinic**” |
| **Enrollee County** | The county, or counties where enrollees are located, who had clinical encounters with the specialty reported.  Enter a new row for each applicable county. Data on all other fields must be included for each row.  Include both the enrollees for whom the reporting plan arranges care and enrollees that the reporting plan has delegated to one or more subcontracted plans, as applicable.  Report data in this field according to the definition for clinical encounters, and the definition for the clinical data capture timeframe, as set forth in the Definition section of the Instruction Manual.  If there are no clinical encounters for the reported specialty type during the clinical data capture timeframe, **and** the third-party corporate telehealth provider became available to enrollees after December 31, 2024, enter “**New Specialty**” in this field.  If the Plan is unable to report the county or counties where enrollees are located who had clinical encounters with the specialty type reported, refer to the forthcoming “Web Portal Validations and Technical Data Specifications” for omitting reporting in this field for RY 2025. Enter all other required demographic data for enrollees who accessed the specialty reported, in the respective fields for the specialty type reported. |
| **Enrollees: Ages 0-18** | The number of enrollees aged 0-18, who had clinical encounters with the reported specialty, within the reported county or counties.  Include both the enrollees for whom the reporting plan arranges care and enrollees that the reporting plan has delegated to one or more subcontracted plans, as applicable.  Report data in this field according to the definition for clinical encounters, and the definition for the clinical data capture timeframe, as set forth in the Definition section of the Instruction Manual.  If the reported specialty type was not available to enrollees through a third-party corporate telehealth provider prior to January 1, 2025, **and** the Plan has no available enrollee demographic data pertaining to the clinical data capture timeframe for the specialty type, enter “**New Specialty**” in this field. |
| **Enrollees: Ages 19-44** | The number of enrollees aged 19-44, who had clinical encounters with the reported specialty, within the reported county or counties.  Include both the enrollees for whom the reporting plan arranges care and enrollees that the reporting plan has delegated to one or more subcontracted plans, as applicable.  Report data in this field according to the definition for clinical encounters, and the definition for the clinical data capture timeframe, as set forth in the Definition section of the Instruction Manual.  If the reported specialty type was not available to enrollees through a third-party corporate telehealth provider prior to January 1, 2025, **and** the Plan has no available enrollee demographic data pertaining to the clinical data capture timeframe for the specialty type, enter “**New Specialty**” in this field. |
| **Enrollees: Ages 45-64** | The number of enrollees aged 45-64, who had clinical encounters with the reported specialty, within the reported county or counties.  Include both the enrollees for whom the reporting plan arranges care and enrollees that the reporting plan has delegated to one or more subcontracted plans, as applicable.  Report data in this field according to the definition for clinical encounters, and the definition for the clinical data capture timeframe, as set forth in the Definition section of the Instruction Manual.  If the reported specialty type was not available to enrollees through a third-party corporate telehealth provider prior to January 1, 2025, **and** the Plan has no available enrollee demographic data pertaining to the clinical data capture timeframe for the specialty type, enter “**New Specialty**” in this field. |
| **Enrollees: Ages 65+** | The number of enrollees aged 65 or older, who had clinical encounters with the reported specialty, within the reported county or counties.  Include both the enrollees for whom the reporting plan arranges care and enrollees that the reporting plan has delegated to one or more subcontracted plans, as applicable.  Report data in this field according to the definition for clinical encounters, and the definition for the clinical data capture timeframe, as set forth in the Definition section of the Instruction Manual.  If the reported specialty type was not available to enrollees through a third-party corporate telehealth provider prior to January 1, 2025, **and** the Plan has no available enrollee demographic data pertaining to the clinical data capture timeframe for the specialty type, enter “**New Specialty**” in this field. |
| **Enrollee Gender: Identified as Male** | The number of enrollees within the reported county or counties, who had clinical encounters with the reported specialty, and who identified as male.  Include both the enrollees for whom the reporting plan arranges care and enrollees that the reporting plan has delegated to one or more subcontracted plans, as applicable.  Report data in this field according to the definition for clinical encounters, and the definition for the clinical data capture timeframe, as set forth in the Definition section of the Instruction Manual.  If the reported specialty type was not available to enrollees through a third-party corporate telehealth provider prior to January 1, 2025, **and** the Plan has no available enrollee demographic data pertaining to the clinical data capture timeframe for the specialty type, enter “**New Specialty**” in this field. |
| **Enrollee Gender: Identified as Female** | The number of enrollees within the reported county or counties, who had clinical encounters with the reported specialty, and who identified as female.  Include both the enrollees for whom the reporting plan arranges care and enrollees that the reporting plan has delegated to one or more subcontracted plans, as applicable.  Report data in this field according to the definition for clinical encounters, and the definition for the clinical data capture timeframe, as set forth in the Definition section of the Instruction Manual.  If the reported specialty type was not available to enrollees through a third-party corporate telehealth provider prior to January 1, 2025, **and** the Plan has no available enrollee demographic data pertaining to the clinical data capture timeframe for the specialty type, enter “**New Specialty**” in this field. |
| **Enrollee Gender: Identified as Something Else Other than Male or Female** | The number of enrollees within the reported county or counties, who had clinical encounters with the reported specialty, and who identified as something else, not male or female.  Include both the enrollees for whom the reporting plan arranges care and enrollees that the reporting plan has delegated to one or more subcontracted plans, as applicable.  Report data in this field according to the definition for clinical encounters, and the definition for the clinical data capture timeframe, as set forth in the Definition section of the Instruction Manual.  If the reported specialty type was not available to enrollees through a third-party corporate telehealth provider prior to January 1, 2025, **and** the Plan has no available enrollee demographic data pertaining to the clinical data capture timeframe for the specialty type, enter “**New Specialty**” in this field. |
| **Enrollee Gender: Unspecified** | The number of enrollees within the reported county or counties, who had clinical encounters with the reported specialty, and who did not identify a gender.  Include both the enrollees for whom the reporting plan arranges care and enrollees that the reporting plan has delegated to one or more subcontracted plans, as applicable.  Report data in this field according to the definition for clinical encounters, and the definition for the clinical data capture timeframe, as set forth in the Definition section of the Instruction Manual.  If the reported specialty type was not available to enrollees through a third-party corporate telehealth provider prior to January 1, 2025, **and** the Plan has no available enrollee demographic data pertaining to the clinical data capture timeframe for the specialty type, enter “**New Specialty**” in this field. |
| **Count of Enrollees** | The total number of enrollees within the reported county or counties, who had clinical encounters with the reported specialty.  Include both the enrollees for whom the reporting plan arranges care and enrollees that the reporting plan has delegated to one or more subcontracted plans, as applicable.  Report data in this field according to the definition for clinical encounters, and the definition for the clinical data capture timeframe, as set forth in the Definition section of the Instruction Manual.  If the reported specialty type was not available to enrollees through a third-party corporate telehealth provider prior to January 1, 2025, **and** the Plan has no available enrollee demographic data pertaining to the clinical data capture timeframe for the specialty type, enter “**New Specialty**” in this field. |
| **Frequency of Use** | The number of clinical encounters within the reported county or counties, which the reported specialty type had with enrollees during the data capture period.  Include clinical encounters pertaining to both the enrollees for whom the reporting plan arranges care and enrollees that the reporting plan has delegated to one or more subcontracted plans, as applicable.  Report data in this field according to the definition for clinical encounters, and the definition for the clinical data capture timeframe, as set forth in the Definition section of the Instruction Manual.  If the reported specialty type was not available to enrollees through a third-party corporate telehealth provider prior to January 1, 2025, **and** the Plan has no available enrollee demographic data pertaining to the clinical data capture timeframe for the specialty type, enter “**New Specialty**” in this field. |

## Non-Network Provider Arrangements Report Form (Form No. 40-287): Instructions

This report form consists of two tabs: The Non-Network Requests Report Tab and the Limited Plan Provider Report Tab.

When completing this report form, all health plans shall complete the Non-Network Requests Report Tab and the Limited Plan Provider Report Tab in the manner described in the field instructions for each respective tab. (Rule 1300.67.2.2(h)(7)(B).)

### 1. Non-Network Requests Report Tab (Form No. 40-287): Instructions

All health plans that are required to report annual network data shall submit the Non-Network Requests Report Tab, as applicable, in the manner described in the field instructions below. (Rules 1300.67.2.2(h)(7)(A)(vii) and (B)(ix).)

Refer to the definitions of "network provider," and "unavailable" provider type or service within Rule 1300.67.2.2(b), to complete this form.

Within the Non-Network Requests Report Tab, for each reported network, report all non-network provider requests and determinations during the timely access compliance measurement year, as defined in Rule 1300.67.2.2(b)(4)(A).

For RY 2025, the plan is required to report non-network provider requests related to the following reasons:

* Provider not accepting new patients
* Timely access to provider
* Specialized procedure/area of expertise
* Geographic accessibility of provider
* Provider type specialty or covered service unavailable

The Plan may report non-network provider requests related to the following reasons:

* Continuity of care
* Member’s preference
* Second opinion
* Other

A non-network provider means an individual provider, an entity or a facility, as set forth in section 1345(i), that does not meet the definition of network provider in Rule 1300.67.2.2(b)(10).

If the reporting plan contracts with a subcontracted plan or a non-plan entity to handle any of the non-network provider requests, grievances, or utilization management (e.g., provider group, or other health services management company) for the network, the reporting plan shall report all such non-network provider requests lodged by primary plan enrollees with the subcontracted plan or non-plan entity.

The instructions below describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the definitions in Rule 1300.67.2.2(b) and the Definitions section of this Instruction Manual for additional explanation of the terms used in the instructions below. Refer to the Reporting Multiple Entries for the Same Data Field and Reporting with Standardized Terminology subsections in the General Instructions Applicable to All Required Report Forms section of this Instruction Manual for more information about how to complete these fields.

### 2. Limited Plan Provider Report Tab (Form No. 40-287): Instructions

The health plan shall report a limited plan provider in the Annual Network Report submission if the plan uses the limited plan provider to deliver access to care when a network provider is unavailable, as defined in Rule 1300.67.2.2(b).

Health plans shall submit the Limited Plan Provider Report Tab in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B).) Within the Limited Plan Provider Report Form, for each reported network, report a complete list of the health plan’s limited plan providers who deliver primary care, specialty care, mental health, other outpatient provider services, and facility-based care, as of the network capture date.

**Limited Plan Providers are Not Network Providers**

Only report providers who meet the definition of “limited plan provider” on this report form.

"Limited plan provider" is defined in Rule 1300.67.2.2(b) as the following:

"Limited plan provider" means any provider as defined in subsection (i) of section 1345 of the Knox-Keene Act, located inside or outside of the network service area of a designated network, who would meet the criteria for "network provider" defined in subsection (b)(10) of Rule 1300.67.2.2, **except** the provider is not accessible to some or all enrollees in the network under the criteria defined in subsection (b)(10)(C) of this Rule. When a plan uses limited plan providers to deliver covered services, the limited plan provider must be available at the lowest-cost sharing tier, and meet the timely access and network adequacy standards, including those set forth in Sections 1367 and 1367.03(a), Rules 1300.67.2.2(c), 1300.51 and 1300.67.2.

Limited plan providers do not meet the definition of "network provider" and are therefore not considered for the purposes of measuring health plans for network adequacy under the requirements set forth in the Act and supporting regulations. In addition, limited plan providers shall not be reported on report forms reserved for network providers.

**Further Reporting Instructions:**

Report all licensed providers that are limited plan providers as individual providers, as defined, using the first name and last name fields. If the limited plan provider is an entity at which unlicensed individual providers are available to provide covered services, and the health plan does not have the first and last names of the unlicensed individual providers, the plan may enter the entity name in the entity name field, rather than enter each individual unlicensed provider at the entity.

The following field instructions describe the data that the reporting health plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the Definitions section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the Reporting Multiple Entries for the Same Data Field and Reporting with Standardized Terminology subsections in the General Instructions Applicable to All Required Report Forms section of this Instruction Manual for more information about how to complete these fields.

**Non-Network Requests Report Tab**

| **FIELD NAME -** NON-NETWORK REQUESTS | **FIELD INSTRUCTIONS -** NON-NETWORK REQUESTS  For each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The network name within which the enrollee was enrolled on the date of the non-network provider request or determination, as defined in Rule 1300.67.2.2(b)(9). |
| **Network ID** | The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Product Line** | The product line within which the enrollee was enrolled, as set forth in **Appendix A** of the Instruction Manual, on the date of the non-network provider request. |
| **Subcontracted Plan Information** | |
| **Subcontracted Plan License Number** | The subcontracted plan license number. Complete this field if the reporting plan has a plan-to-plan contract with a subcontracted plan for the delivery of services to enrollees within the network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13), and the non-network provider request was made to the subcontracted plan, or it concerns a provider or provider type that was the contractual responsibility of the subcontracted plan to arrange. Each health plan's license number is available in the Department's web portal. |
| **Subcontracted Plan Network ID** | The subcontracted plan network identifier. Complete this field if the reporting plan has a plan-to-plan contract with a subcontracted plan’s network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13), and the non-network provider request was made to the subcontracted plan, or it concerns a provider or provider type that was the contractual responsibility of the subcontracted plan to arrange. |
| **Non-Network Request Information** | |
| **Date of Request** | The date the non-network provider request was made to the health plan or health plan delegate. |
| **Reason for Request** | The reason the non-network provider request was made on behalf of the enrollee (regardless of the plan’s final determination). The following are reasons for non-network provider requests:   * Provider not accepting new patients * Timely access to provider * Specialized procedure/area of expertise * Geographic accessibility of provider * Provider type specialty or covered service unavailable * Continuity of care * Member’s preference * Second opinion * Other |
| **Date of Determination** | The date the health plan made a determination of whether to approve the non-network provider request or the request was otherwise resolved. |
| **Determination** | The status of the plan's determination. Whether the health plan approved the request, denied the request, or there was a different resolution.  Enter partial approval if a non-network provider request was approved with modifications. |
| **Reason for Denial or Partial Approval** | If the health plan denied the request, or approved the request with modifications, enter the reason for denial or modification. |
| **Date of Referral** | If the health plan approved the request, or approved the request with modifications, enter the date the plan issued a referral to the non-network provider. |
| **Request ID** | The reporting plan’s unique identifier for the non-network provider request. If the request was lodged with a delegated entity, the unique identifier assigned by the delegated entity. |
| **County** | The county where the enrollee resides or works. |
| **Provider Group** | If the enrollee was assigned to a provider group at the time of the non-network provider request, the name of the provider group. |
| **Provider Type Category** | The category of provider that is the subject of the non-network provider request. The category of provider type that corresponds to the specialty reported in the “Specialty” field. **Appendix B** sets forth the provider type categories, in the title of each specialty table. Select among the following categories, as applicable:  Primary Care Physician: enter “**PCP**” Specialist Physician: enter “**Specialist**” Primary Care Non-Physician Medical Practitioner: enter “**PCP NPMP**” Specialist Non-Physician Medical Practitioner: enter “**Specialist NPMP**” Non-Physician Mental Health Professional: enter “**MHP**” Other Outpatient Provider: enter “**OOP**” Mental Health Facility: enter “**MHF**” Hospital: enter "**Hospital**" Clinic: enter “**Clinic**” |
| **Specialty** | The specialty or subspecialty of the provider that is the subject of the non-network provider request. Report the applicable specialty or subspecialty, as set forth within the tables in **Appendix B**. The specialty reported should correspond to the Provider Type Category under which the specialty is classified, as reported in the “Provider Type Category” field.  If the provider is a non-physician mental health professional (MHP) specialty, list the specialty in this field and the corresponding license or certificate in the "Type of License/Certificate" field in the same row. |
| **Type of License / Certificate** | The license or certificate type of the provider type that is the subject of the non-network provider request. The entry shall reflect the provider’s license or certificate type. See **Appendix D** for the list of provider license or certificate types. |

**Limited Plan Provider Report Tab**

| **FIELD NAME -** LIMITED PLAN PROVIDER | **FIELD INSTRUCTIONS -** LIMITED PLAN PROVIDER For each required field, enter the following data: |
| --- | --- |
| **Network Information** | |
| **Network Name** | The network name for which the plan makes the limited plan provider available, as defined in Rule 1300.67.2.2(b)(9). |
| **Network ID** | The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal. |
| **Subcontracted Plan Information** | |
| **Subcontracted Plan License Number** | The subcontracted plan license number. Complete this field if the reporting plan includes the limited plan provider through a plan-to-plan contract with a subcontracted plan, as described in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). Each health plan's license number is available on the Department's web portal. |
| **Subcontracted Plan Network ID** | The subcontracted plan network identifier. Complete this field if the reporting plan includes the limited plan provider through a plan-to-plan contract with a subcontracted plan’s network, as the terms are defined in Rules 1300.67.2.2(b)(10)(B)(iv) and (b)(13). |
| **Limited Plan Provider Information** | |
| **Last Name** | Last name of the limited plan provider. |
| **First Name** | First name of the limited plan provider. |
| **Entity Name** | If the health plan reported an individual limited plan provider that delivers services through an entity, report the legal name of the entity in this field. If the limited plan provider is an entity at which unlicensed individual providers are available to provide covered services, the health plan may enter the entity as the limited plan provider. |
| **NPI** | The unique National Provider Identifier (NPI) assigned to the limited plan provider and active on the network capture date. |
| **CA License / Certificate** | California license or certificate identifier of the limited plan provider, active on the network capture date. |
| **Non-CA License / Certificate** | License number or certificate identifier issued outside of the state of California, active on the network capture date. |
| **Non-CA License / Certificate State** | State in which the non-California license or certificate was issued. |
| **Provider Type Category** | The category of provider type that corresponds to the specialty reported in the “Specialty” field. **Appendix B** sets forth the provider type categories, in the title of each specialty table. Select among the following categories:  Primary Care Physician: enter “**PCP**” Specialist Physician: enter **“Specialist**” Primary Care Non-Physician Medical Practitioner: enter “**PCP NPMP**” Specialist Non-Physician Medical Practitioner: enter “**Specialist NPMP**” Non-Physician Mental Health Professional: enter “**MHP**” Other Outpatient Provider: enter “**OOP**” Mental Health Facility: enter “**MHF**” Hospital: enter "**Hospital**" Clinic: enter “**Clinic**” |
| **Type of License / Certificate** | The limited plan provider’s type of license or certificate, as set forth in **Appendix D**. |
| **Specialty** | The limited plan provider’s specialty, subspecialty, or area of expertise, as set forth in **Appendix B**. |
| **Board Certified / Eligible** | For each reported specialty or subspecialty, indicate whether the limited plan provider is board-certified or board-eligible. |
| **Provider Group** | Name of the provider group affiliated with the limited plan provider, if applicable. |
| **Provider Language 1** | Language spoken by the limited plan provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 2** | Language spoken by the limited plan provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Provider Language 3** | Language spoken by the limited plan provider, other than English, as set forth in **Appendix C**, if applicable. |
| **Limited Plan Provider Practice Location and Associated Information** | |
| **Practice Address** | The street number and street name of the practice address. If the limited plan provider also serves as a telehealth provider, report only the physical locations at which the limited plan provider delivers in-person health care services. |
| **Practice Address 2** | The number of the office, suite, building or other location identifier for the practice address, if applicable. |
| **City** | City in which the practice address is located. |
| **County** | County in which the practice address is located. |
| **State** | State in which the practice address is located. |
| **ZIP Code** | ZIP Code in which the practice address is located. |
| **Number of Limited Plan Providers at Entity** | If the health plan reported the limited plan provider information by “Entity Name,” the number of providers within the entity who are limited plan providers, for each specialty type reported. |
| **In-Person Appointments** | The availability of the limited plan provider to offer in-person appointments on an outpatient basis as the term is defined in Rule 1300.67.2.2(b). |

# Standardized Terminology Appendices

## Appendix A: Product Line Categories

| **Standardized Terminology**  **Product Line Categories** |
| --- |
| Covered CA EPO Individual Market |
| Covered CA EPO Small Group Market |
| Covered CA HMO Individual Market |
| Covered CA HMO Small Group Market |
| Covered CA POS Individual Market |
| Covered CA POS Small Group Market |
| Covered CA PPO Individual Market |
| Covered CA PPO Small Group Market |
| Employer Group |
| EPO Individual Market |
| EPO Large Group Market |
| EPO Small Group Market |
| Healthy Kids |
| HMO Individual Market |
| HMO Large Group Market |
| HMO Small Group Market |
| IHSS |
| MMP/EAE- DSNP (Formerly Cal MediConnect) |
| Medi-Cal |
| Medi-Cal Access (AIM) |
| Medicare |
| MRMIP |
| POS Individual Market |
| POS Large Group Market |
| POS Small Group Market |
| PPO Individual Market |
| PPO Large Group Market |
| PPO Small Group Market |
| Specialized Mental Health Commercial Market |
| Other |

## Appendix B: Provider Types

| **Standardized Terminology**  **Clinic Type** |
| --- |
| Alternative Birthing Center |
| Ambulatory Surgery Center/Surgical Clinic |
| Chronic Dialysis Clinic |
| Community Clinic |
| Federally Qualified Health Center (FQHC) |
| Free Standing - Primary Care |
| Free Standing - Specialty Care |
| Free Clinic |
| Psychology Clinic |
| Rehabilitation Clinic |
| Retail Health Clinic |
| Rural Health |
| Urgent Care Center |
| Telehealth Urgent Care |
| Other Outpatient Facility |

| **Standardized Terminology**  **Hospital and Other Inpatient Facility Type** |
| --- |
| Acute Psychiatric Hospital |
| Chemical Dependency Recovery Hospital |
| Congregate Living Health Facility |
| General Acute Care Hospital |
| Hospice Facility |
| Intermediate Care Facility for Individuals with Intellectual Disabilities |
| Inpatient Rehabilitation |
| Intermediate Care Facility |
| Psychiatric Health Facility |
| Skilled Nursing Facility |
| Other Inpatient Facility |

| **Standardized Terminology**  **Mental Health Facility Type (MHF)** |
| --- |
| Alcohol and Other Drug (Outpatient) |
| Community Mental Health Center |
| Crisis Residential Facility |
| Crisis Stabilization Facility |
| Eating Disorder (Inpatient) |
| Eating Disorder (Outpatient) |
| Intensive Outpatient |
| Medication Assisted Treatment Programs |
| Mental Health Rehabilitation Center |
| Partial Hospitalization |
| Residential Treatment |
| Residential Detox |
| Other |

| **Standardized Terminology**  **Non-Physician Medical Practitioner Specialty Type**  **(NPMP, PCP NPMP or Specialist NPMP)** |
| --- |
| Adult Nurse Practitioner |
| Cardiovascular & Thoracic Surgery Physician Assistant |
| Clinical Nurse Specialist |
| Emergency Medicine Physician Assistant |
| Family Nurse Practitioner |
| Hospital Medicine Physician Assistant |
| Nephrology Physician Assistant |
| Nurse Anesthetist |
| Nurse-Midwife |
| Obstetrical-Gynecological Nurse Practitioner |
| Orthopaedic Surgery Physician Assistant |
| Pediatric Nurse Practitioner |
| Pediatrics Physician Assistant |
| Psychiatric-Mental Health Nurse |
| Psychiatry Physician Assistant |
| Public Health Nurse |
| Other |

| **Standardized Terminology**  **Non-Physician Mental Health Professional Specialty Type (MHP)** |
| --- |
| Adult |
| Adolescent |
| Alcohol and Other Drugs |
| Child |
| Geriatric |
| Prenatal and Maternal Mental Health |
| Qualified Autism Services Paraprofessional |
| Qualified Autism Services Professional |
| Qualified Autism Services Provider |
| Other |

| **Standardized Terminology**  **Other Outpatient Provider Type (OOP)** |
| --- |
| Acupuncture |
| Ambulance/Transport |
| Audiology |
| Chiropractic |
| Dialysis:In-Home or Hospital Outpatient |
| Dietician/Nutrition |
| Doula Services |
| Durable Medical Equipment/Supplies |
| Endodontics |
| Family Planning |
| General Dentist |
| Home Health Nurse |
| Hospice |
| Imaging/Radiology |
| Infusion/IV Therapy |
| Laboratory |
| Licensed Home Health Agency |
| Mammography |
| Nurse |
| Nurse Practitioner |
| Occupational Therapy |
| Optometry/Vision |
| Orthodontics |
| Orthotics/Prosthetics |
| Pediatric Dentistry |
| Periodontics |
| Pharmacy |
| Physical Therapy |
| Physician Assistant |
| Prosthodontics |
| Sleep Disorder Diagnosis/Treatment |
| Speech Therapy |
| Surgery – Oral |
| Other |

| **Standardized Terminology**  **Primary Care Physician Specialty Type (PCP)** |
| --- |
| Family Practice |
| General Practice |
| Internal Medicine |
| Obstetrics/Gynecology |
| Pediatrics |
| Other |

| **Standardized Terminology**  **Specialist Physician Specialty Type** | | |
| --- | --- | --- |
| (Includes related ABMS designations, if different from the standardized terminology,  and the ABMS Board(s) from which the specialty is issued.) | | |
| **Specialist Physician Specialty** | **ABMS Designation (for reference)** | **ABMS Board (for reference)** |
| Addiction Medicine |  | Board of Preventive Medicine |
| Addiction Psychiatry |  | Board of Psychiatry and Neurology |
| Adult Congenital Heart Disease |  | Board of Internal Medicine |
| Advanced Heart Failure and Transplant Cardiology |  | Board of Internal Medicine |
| Allergy/Immunology |  | Board of Allergy and Immunology |
| Anesthesiology |  | Board of Anesthesiology |
| Brain Injury Medicine |  | Board of Physical Medicine and Rehabilitation; Board of Psychiatry and Neurology |
| Cardiovascular Disease |  | Board of Internal Medicine |
| Child and Adolescent Psychiatry |  | Board of Psychiatry and Neurology |
| Clinical Cardiac Electrophysiology |  | Board of Internal Medicine |
| Clinical Neurophysiology |  | Board of Psychiatry and Neurology |
| Consultation-Liaison Psychiatry |  | Board of Psychiatry and Neurology |
| Critical Care Medicine | Critical Care Medicine; Anesthesiology Critical Care Medicine; Internal Medicine-Critical Care Medicine | Board of Anesthesiology; Board of Emergency Medicine; Board of Internal Medicine; Board of Obstetrics and Gynecology; Board of Pediatrics |
| Dermatology |  | Board of Dermatology |
| Dermatopathology |  | Board of Dermatology; Board of Pathology |
| Diagnostic Radiology | Diagnostic Radiology; Interventional Radiology and Diagnostic Radiology | Board of Radiology |
| Emergency Medicine | Emergency Medical Services | Board of Emergency Medicine |
| Endocrinology | Endocrinology, Diabetes and Metabolism | Board of Internal Medicine |
| Epilepsy |  | Board of Psychiatry and Neurology |
| Female Pelvic Medicine and Reconstructive Surgery |  | Board of Obstetrics and Gynecology; Board of Urology |
| Forensic Psychiatry |  | Board of Psychiatry and Neurology |
| Gastroenterology |  | Board of Internal Medicine |
| Genetics | Clinical Biochemical Genetics; Clinical Genetics and Genomics (MD); Clinical Molecular Genetics and Genomics; Clinical Cytogenetics and Genomics | Board of Medical Genetics and Genomics |
| Geriatric Medicine |  | Board of Family Medicine; Board of Internal Medicine |
| Geriatric Psychiatry |  | Board of Psychiatry and Neurology |
| Gynecologic Oncology |  | Board of Obstetrics and Gynecology |
| Hematology |  | Board of Internal Medicine |
| HIV/AIDS Specialist |  | Rule 1300.74.16 |
| Hospice and Palliative Medicine |  | Board of Anesthesiology; Board of Emergency Medicine; Board of Family Medicine, Board of Internal Medicine; Board of Obstetrics and Gynecology; Board of Pediatrics; Board of Physical Medicine and Rehabilitation; Board of Psychiatry and Neurology; Board of Radiology; Board of Surgery |
| Infectious Disease |  | Board of Internal Medicine |
| Internal Medicine |  | Board of Internal Medicine |
| Interventional Cardiology |  | Board of Internal Medicine |
| Maternal and Fetal Medicine |  | Board of Obstetrics and Gynecology |
| Medical Toxicology |  | Board of Emergency Medicine; Board of Pediatrics; Board of Preventive Medicine |
| Neonatology | Neonatal-Perinatal Medicine | Board of Internal Medicine, Board of Pediatrics |
| Nephrology |  | Board of Internal Medicine |
| Neurodevelopmental Disabilities |  | Board of Psychiatry and Neurology |
| Neurology |  | Board of Psychiatry and Neurology |
| Neuromuscular Medicine |  | Board of Physical Medicine and Rehabilitation; Board of Psychiatry and Neurology |
| Nuclear Medicine |  | Board of Nuclear Medicine |
| Obstetrics/Gynecology |  | Board of Obstetrics and Gynecology |
| Occupational Medicine |  | Board of Preventive Medicine |
| Oncology | Medical Oncology | Board of Internal Medicine |
| Ophthalmology |  | Board of Ophthalmology |
| Otolaryngology |  | Board of Otolaryngology - Head and Neck Surgery |
| Pain Medicine |  | Board of Anesthesiology; Board of Emergency Medicine; Board of Family Medicine; Board of Physical Medicine and Rehabilitation; Board of Psychiatry and Neurology; Board of Radiology |
| Pathology | Pathology – Anatomic/Pathology – Clinical; Pathology – Anatomic; Pathology – Clinical | Board of Pathology |
| Pediatric Anesthesiology |  | Board of Anesthesiology |
| Pediatric Cardiology |  | Board of Pediatrics |
| Pediatric Critical Care Medicine |  | Board of Pediatrics |
| Pediatric Dermatology |  | Board of Dermatology |
| Pediatric Developmental-Behavioral |  | Board of Pediatrics |
| Pediatric Endocrinology |  | Board of Pediatrics |
| Pediatric Gastroenterology |  | Board of Pediatrics |
| Pediatric Hematology/Oncology |  | Board of Pediatrics |
| Pediatric Infectious Disease |  | Board of Pediatrics |
| Pediatric Nephrology |  | Board of Pediatrics |
| Pediatric Neurology | Neurology with Special Qualification in Child Neurology | Board of Psychiatry and Neurology |
| Pediatric Otolaryngology | Complex Pediatric Otolaryngology | Board of Otolaryngology - Head and Neck Surgery |
| Pediatric Pulmonology |  | Board of Pediatrics |
| Pediatric Radiology |  | Board of Radiology |
| Pediatric Rehabilitation Medicine |  | Board of Physical Medicine and Rehabilitation |
| Pediatric Rheumatology |  | Board of Pediatrics |
| Pediatric Surgery |  | Board of Surgery |
| Pediatric Transplant Hepatology |  | Board of Pediatrics |
| Pediatric Urology |  | Board of Urology |
| Physical Medicine and Rehabilitation |  | Board of Physical Medicine and Rehabilitation |
| Podiatry |  | CA Board of Podiatric Medicine |
| Psychiatry |  | Board of Psychiatry and Neurology |
| Pulmonology | Pulmonary Disease | Board of Internal Medicine |
| Radiation Oncology |  | Board of Radiology |
| Reproductive Endocrinology/Infertility |  | Board of Obstetrics and Gynecology |
| Rheumatology |  | Board of Internal Medicine |
| QASP Physician | Qualified Autism Services Provider, as defined in Health and Safety Code section 1374.73, sub. (c) |  |
| Sleep Medicine |  | Board of Anesthesiology; Board of Family Medicine; Board of Internal Medicine; Board of Otolaryngology - Head and Neck Surgery; Board of Pediatrics; Board of Psychiatry and Neurology |
| Sports Medicine | Sports Medicine | Board of Emergency Medicine; Board of Family Medicine; Board of Internal Medicine; Board of Pediatrics; Board of Physical Medicine and Rehabilitation |
| Surgery – Cardiothoracic | Thoracic and Cardiac Surgery | Board of Thoracic Surgery |
| Surgery – Colon/Rectal |  | Board of Colon and Rectal Surgery |
| Surgery – Congenital Cardiac |  | Board of Thoracic Surgery |
| Surgery – Critical Care | Surgical Critical Care | Board of Surgery |
| Surgery – General | Surgery | Board of Surgery |
| Surgery – Hand | Surgery of the Hand | Board of Orthopaedic Surgery; Board of Plastic Surgery; Board of Surgery |
| Surgery – Neurological |  | Board of Neurological Surgery |
| Surgery – Oncology | Complex General Surgical Oncology | Board of Surgery |
| Surgery – Orthopaedic | Orthopaedic Surgery; Orthopaedic Sports Medicine | Board of Orthopaedic Surgery |
| Surgery – Plastic | Plastic Surgery; Plastic Surgery Within the Head and Neck | Board of Plastic Surgery; Board of Otolaryngology - Head and Neck Surgery |
| Surgery – Thoracic |  | Board of Thoracic Surgery |
| Surgery – Vascular |  | Board of Surgery |
| Transplant Hepatology |  | Board of Internal Medicine |
| Urology |  | Board of Urology |
| Vascular Neurology |  | Board of Psychiatry and Neurology |
| Other |  |  |
|  |  |  |

## Appendix C: Provider Languages

| **Standardized Terminology**  **Provider Languages** |
| --- |
| Abnaki |
| Achinese |
| Achumawi |
| African |
| Afrikaans |
| Ahtena |
| Alabama |
| Albanian |
| Aleut |
| Algonquian |
| American Indian |
| American Sign Language |
| Amharic |
| Apache |
| Arabic |
| Arapaho |
| Arawakian |
| Arikara |
| Armenian |
| Assamese |
| Athapascan |
| Atsina |
| Atsugewi |
| Aymara |
| Azerabaijani |
| Aztecan |
| Balinese |
| Balochi |
| Bantu |
| Basque |
| Bengali |
| Berber |
| Bielorussian |
| Bihari |
| Bikol |
| Bisayan |
| Blackfoot |
| Bulgarian |
| Burmese |
| Caddo |
| Cahuilla |
| Cajun |
| Cambodian |
| Cantonese |
| Carolinian |
| Catalonian |
| Cayuga |
| Chadic |
| Cham |
| Chamorro |
| Chasta Costa |
| Chemehuevi |
| Cherokee |
| Chetemacha |
| Cheyenne |
| Chibchan |
| Chinese |
| Chinook Jargon |
| Chiricahua |
| Chiwere |
| Choctaw |
| Chumash |
| Clallam |
| Cocomaricopa |
| Coeur D'alene |
| Columbia |
| Comanche |
| Cowlitz |
| Cree |
| Croatian |
| Crow |
| Cupeno |
| Cushite |
| Czech |
| Dakota |
| Danish |
| Delaware |
| Delta River Yuman |
| Diegueno |
| Dravidian |
| Dutch |
| Efik |
| Eskimo |
| Estonian |
| Faroese |
| Farsi |
| Fijian |
| Finnish |
| Foothill North Yokuts |
| Formosan |
| Fox |
| French |
| French Creole |
| Frisian |
| Fuchow |
| Fulani |
| German |
| Gilbertese |
| Gondi |
| Greek |
| Gujarati |
| Gullah |
| Gur |
| Haida |
| Hakka |
| Havasupai |
| Hawaiian |
| Hawaiian Pidgin |
| Hebrew |
| Hidatsa |
| Hindi |
| Hmong |
| Hopi |
| Hungarian |
| Hupa |
| Icelandic |
| Ilocano |
| Indonesian |
| Ingalit |
| Inupik |
| Irish Gaelic |
| Iroquois |
| Italian |
| Jamaican Creole |
| Japanese |
| Javanese |
| Jicarilla |
| Kachin |
| Kan, Hsiang |
| Kannada |
| Kansa |
| Karachay |
| Karen |
| Karok |
| Kashmiri |
| Kazakh |
| Keres |
| Khoisan |
| Kickapoo |
| Kiowa |
| Kirghiz |
| Klamath |
| Koasati |
| Korean |
| Koyukon |
| Krio |
| Kru, Ibo, Yoruba |
| Kuchin |
| Kurdish |
| Kusaiean |
| Kutenai |
| Kwakiutl |
| Ladino |
| Laotian |
| Lettish |
| Lithuanian |
| Luiseno |
| Lusatian |
| Luxembourgian |
| Macedonian |
| Makah |
| Malagasy |
| Malay |
| Malayalam |
| Mandan |
| Mandarin |
| Mande |
| Maori |
| Mapuche |
| Marathi |
| Marquesan |
| Marshallese |
| Mayan languages |
| Mbum |
| Melanesian |
| Menomini |
| Miami |
| Miao-yao, Mien |
| Micmac |
| Micronesian |
| Mikasuki |
| Misumalpan |
| Mohave |
| Mohawk |
| Mokilese |
| Mongolian |
| Mono |
| Mortlockese |
| Mountain Maidu |
| Munda |
| Muskogee |
| Navajo |
| Nepali |
| Nez Perce |
| Nilo-halitic |
| Nilotic |
| Niuean |
| Nomlaki |
| Nootka |
| Northern Paiute |
| Northwest Maidu |
| Norwegian |
| Nubian |
| Nukuoro |
| Ojibwa |
| Okanogan |
| Omaha |
| Oneida |
| Onondaga |
| Oriya |
| Osage |
| Oto – Mangena |
| Ottawa |
| Pacific Gulf Yupik |
| Paiute |
| Palau |
| Paleo-siberian |
| Pampangan |
| Pangasinan |
| Panjabi |
| Papia Mentae |
| Pashto |
| Passamaquoddy |
| Patois |
| Pawnee |
| Pennsylvania Dutch |
| Penobscot |
| Pidgin |
| Pima |
| Polish |
| Polynesian |
| Pomo |
| Ponapean |
| Ponca |
| Portuguese |
| Potawatomi |
| Puget Sound Salish |
| Quechua |
| Quinault |
| Rajasthani |
| Rarotongan |
| Rhaeto-romanic |
| Romanian |
| Romany |
| Russian |
| Sahaptian |
| Saharan |
| Salish |
| Samoan |
| Santiam |
| Saramacca |
| Scottic Gaelic |
| Sebuano |
| Seneca |
| Serbian |
| Serbocroatian |
| Serrano |
| Shawnee |
| Shoshoni |
| Sierra Miwok |
| Sindhi |
| Sinhalese |
| Siuslaw |
| Slovak |
| Slovene |
| Sonoran |
| Spanish |
| Spokane |
| St Lawrence Island Yupik |
| Sudanic |
| Swahili |
| Swedish |
| Syriac |
| Tachi |
| Tadzhik |
| Tagalog |
| Taiwanese |
| Tamil |
| Tanaina |
| Tarascan |
| Telugu |
| Tewa |
| Thai |
| Tibetan |
| Tiwa |
| Tlingit |
| Tokelauan |
| Tongan |
| Tonkawa |
| Towa |
| Trukese |
| Tsimshian |
| Tungus |
| Tupi-guarani |
| Turkish |
| Turkmen |
| Tuscarora |
| Uighur |
| Ukrainian |
| Ulithean |
| Upper Chinook |
| Urdu |
| Ute |
| Vietnamese |
| Walapai |
| Washo |
| Welsh |
| Wichita |
| Winnebago |
| Wintun |
| Woleai-ulithi |
| Wu |
| Yapese |
| Yaqui |
| Yavapai |
| Yiddish |
| Yuchi |
| Yuma |
| Yupik |
| Yurok |
| Zuni |

## Appendix D: Type of License or Certificate

| **Standardized Terminology**  **Mental Health Professional License and Certificate Type** |
| --- |
| Alcohol and Other Drug Counselor |
| Associate Clinical Social Worker |
| Associate Marriage and Family Therapist |
| Associate Professional Clinical Counselor |
| Board Certified Behavior Analyst |
| Board Certified Assistant Behavior Analyst |
| Licensed Clinical Social Worker |
| Licensed Marriage and Family Therapist |
| Licensed Professional Clinical Counselor |
| Psychiatric-Mental Health Nurse |
| Psychiatric Physician Assistant |
| Psychologist |
| Perinatal Mental Health Certified |
| Registered Psychological Associate |
| Trainee |
| Other License |
| Other Certificate |

| **Standardized Terminology**  **Non-Physician Medical Practitioner License and Certificate Type** |
| --- |
| Certified Nurse Midwife |
| Licensed Midwife |
| Nurse Practitioner |
| Nurse Practitioner - Advanced Practice |
| Physician Assistant |

| **Standardized Terminology**  **Primary Care Physician License Type** | |
| --- | --- |
| **Primary Care Physician License Type** | **Medical Degree (for reference)** |
| DO | Doctor of Osteopathic Medicine |
| MD | Doctor of Medicine |

| **Standardized Terminology**  **Specialist Physician License Type** | |
| --- | --- |
| **Specialist Physician License Type** | **Medical Degree (for reference)** |
| DO | Doctor of Osteopathic Medicine |
| DPM | Doctor of Podiatric Medicine |
| MD | Doctor of Medicine |

## Appendix E: Telehealth Location and Modality Terminology

|  |
| --- |
| **Standardized Terminology**  **Patient Location Type Category** |
| Medical Facility |
| Patient’s Residence |
| Patient’s Personal Mobile Device |
| No Limitation on Location |
| Other |

|  |
| --- |
| **Standardized Terminology**  **Telehealth Delivery Modality Category** |
| Advice |
| e-Consult |
| Live visit |
| Remote Patient Monitoring |
| Store and forward |
| Triage |
| Other |

## Appendix F: Grievance Field Values

|  |
| --- |
| **Standardized Terminology**  **Complaint Category** |
| Geographic Access |
| Language Assistance Plan |
| Language Assistance Provider |
| Office Wait Time |
| Provider Directory Error |
| Provider Not Taking New Patients |
| Telephone Access Plan |
| Telephone Access Provider |
| Timely Access |
| Timely Authorization |
| Other |

|  |
| --- |
| **Standardized Terminology**  **Provider Category** |
| Ancillary Provider |
| Clinic |
| Hospital |
| Mental Health Facility |
| Mental Health Professional |
| PCP |
| PCP Non-Physician Medical Practitioner |
| Plan |
| Provider Group |
| Specialist |
| Specialist Non-Physician Medical Practitioner |

| **Standardized Terminology**  **Nature of Resolution** |
| --- |
| Authorization Approved |
| Authorization Denied |
| Change Medical Group |
| Change PCP |
| Change Specialist |
| Enrollee Educated |
| No Confirmed Access Issue |
| Out-of-Network Referral |
| Provider Educated |
| Re-adjudicated claim |
| Secured Timely Appointment |
| Updated Provider Directory |
| Network Provider Added to the Network |

|  |
| --- |
| **Standardized Terminology**  **Resolution Determination** |
| Enrollee Favor |
| Partial Enrollee Favor |
| Health Plan Favor |

1. References to “section” are to sections of the California Health and Safety Code, including but not limited to section 1340, et seq. (the Knox-Keene Act as codified in the California Health and Safety Code). References to “Rule” are to title 28 of the California Code of Regulations. [↑](#footnote-ref-2)
2. A health plan’s annual submission within the Department’s web portal does not amend or modify the health plan’s original licensing documents, or serve as a request for approval of an amendment or material modification to a health plan’s license. [↑](#footnote-ref-3)