# Checklist for the Provider Directory

Instructions

- The Provider Directory Checklist is to be submitted with your Provider Directory. Both documents should be zipped and submitted as one file.
- Once completed, both documents should be transmitted via the HPMS MA or PDP Marketing Module.

Requirements

All required and relevant information that should be included in the Provider Directory:

| | Page# |
|---|---|
| ___ Marketing material ID | ___ |
| ___ Materials in 12 point font | N/A |
| ___ Include customer service numbers, TTY/TDD number, and hours of operation | ___ |
| ___ Include all required categories | N/A |
| ___ Include names, complete address, and phone numbers of the primary care physicians | ___ |
| ___ Include providers that participate in Medicaid | ___ |
| ___ Include names and addresses (city or town) of specialists, skilled nursing facilities, hospitals, outpatient mental health providers, and pharmacies (if applicable), where outpatient prescription drugs are offered by the MA plan; | ___ |
| ___ Include description of the plan's service area, including a list of cities and towns | ___ |
| ___ Include instructions to enrollees that, in cases where non-contracting providers submit a bill directly to the enrollee, the enrollee should not pay the bill, but submit it to the MA organization for processing and determination of enrollee liability, if any | ___ |
| ___ Include information regarding out-of-area coverage and emergency coverage | ___ |
| ___ Include prior authorization rules (If applicable) | ___ |
| ___ Include prior notification (If applicable) | ___ |
| ___ Pharmacy category included to describe Part B drugs only (If applicable) | ___ |
| ___ No spelling errors | ___ |

Based on my best knowledge, information, and belief, all information submitted to CMS in these documents are accurate, complete, and truthful. Our organization has performed a second quality review of the materials before submitting them to CMS for review and approval.

_____

(Name & Title of preparer of materials/ Date)

_____

(Name & Title of second Quality Reviewer/Date

On behalf of

_____

(NAME OF ORGANIZATION)