



Preferred Facility Handbook

TAP
THE
POWER



**CERTIFIED
Credentialing and
Recredentialing**
Since August 2001



**CERTIFIED
Utilization
Management**
Since May 2001



**ACCREDITED
Health Network
with Credentialing**
Since October 2001



**ACCREDITED
Health Utilization
Management**
Since July 1993

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Introduction

This Preferred Facility Handbook is the “Administrative Manual” referenced in your Preferred Facility Agreement. Please read it carefully and refer to it as questions arise. Please note that if a provision in this Preferred Facility Handbook conflicts with state or federal law or the terms of your Preferred Facility Agreement, the state or federal law or your Preferred Facility Agreement takes precedence. The terms of this Preferred Facility Handbook may be modified at the sole discretion of Private Healthcare Systems, Inc. (PHCS). It also includes guidelines for managing the care of Covered Individuals served by PHCS from the time the Covered Individual initiates care until the time the Preferred Facility receives payment for services.

When the word “you” or “your” appears in this handbook, it means the Preferred Facility that is party to a Preferred Facility Agreement with PHCS.

We are committed to positive relationships with our Network providers and customers. To strengthen these relationships and supply you with the most up-to-date information, we have a variety of information, including the most current version of this Preferred Facility Handbook, on the Provider Access section of *www.phcs.com*. You may also request a current copy of the handbook or our most recent list of payors by calling the PHCS Provider Relations Department toll-free at (800) 950-7040.

Important Definitions

Certification The determination made by a licensed, registered or certified health care professional engaged by the Care Management program that the health care services rendered by a Preferred Professional meet the requirements of care, treatment and supplies for which payment is available by a PHCS Payor pursuant to the Covered Individual's Contract. Certification may also be referred to as "Precertification."

Concurrent Review Utilization Review conducted during a patient's hospital stay or course of treatment.

Contract Any insurance policy, benefit plan or other health plan or program issued or administered by a PHCS Payor.

Covered Care Care, treatment and supplies for which payment is available pursuant to a Contract.

Covered Individual Any individual eligible to receive care, treatment and supplies for which payment is available pursuant to a Contract offered by a PHCS Payor.

Emergency A condition, illness or injury of such a nature that failure to obtain immediate medical care could place the health of a Covered Individual in serious jeopardy. The determination as to whether a condition, illness or injury is an Emergency is made without consideration of whether services provided to treat the Emergency are covered under a Covered Individual's Contract.

PHCS Customer An entity that has entered into an agreement with PHCS for the provision of network management services, care management services and/or other PHCS services.

PHCS Network The **PHCS Preferred Provider Organization** and/or the PHCS select network.

PHCS Open Access A PHCS service option that uses the PHCS select network of tightly organized medical practice organizations to provide services to Covered Individuals. Covered Individuals enrolled in **PHCS Open Access** are not required to use a primary care physician or to obtain referrals to see a specialist. Covered Individuals must see an "in-network" Preferred Professional to avoid a reduction in benefits.

PHCS Payor The party liable for payment, or for arranging payment, for the provision of health care services rendered to a Covered Individual through the PHCS Provider Network.

PHCS Preferred Provider Organization (PPO) A broad, national network of facilities, physicians and other health care providers who have agreed to serve Covered Individuals. PHCS Payors direct Covered Individuals enrolled in the **PHCS Preferred Provider Organization** to providers participating in the **PHCS Network**.

Preferred Provider A licensed facility or licensed, registered or certified health care professional that agrees to provide health care services to Covered Individuals and that has been selected by PHCS for participation in the PHCS Provider Network. Preferred Providers may be referenced in this Preferred Facility Handbook individually as "Preferred Facility," "Preferred Vendor" or "Preferred Professional."

Protected Information Clinical or personal information that could permit the identification of a Covered Individual or Preferred Provider. With respect to Covered Individuals, protected information includes, but is not limited to, medical information and claims data. With respect to Preferred Providers, protected information includes, but is not limited to, information about performance and utilization patterns.

Quality Management Program A program designed to promote quality assurance and improvement activities within an organization and assess the credentials of Preferred Professionals and the quality of health care services rendered by each Preferred Professional. A Quality Management program may include a complaint investigation and resolution process.

Retrospective Review Utilization Review conducted after services have been provided to a Covered Individual.

Care Management Program A program established by or on behalf of a PHCS Payor under which a request for care, treatment and/or supplies may be evaluated against established clinical criteria for medical necessity, appropriateness and efficiency. Sometimes referenced as “Utilization Review.”

Network Participation

Proprietary Information

All information and materials provided to you by PHCS, PHCS Customers or PHCS Payors remains proprietary to PHCS, PHCS Customers or PHCS Payors. This includes, but is not limited to, your Preferred Facility Agreement and its terms, conditions, and negotiations, any contracts, rate or fee information, PHCS Customer or PHCS Payor client lists, any administrative handbook(s), and/or other operations manuals. You may not disclose any of such information or materials or use them except as may be permitted or required by the terms of your Preferred Facility Agreement.

Preferred Professional Responsibilities

As part of the PHCS Preferred Provider Network, you are responsible for meeting certain requirements for network participation. You have the responsibility for:

- The care and treatment of Covered Individuals under your care. You must ensure that all care is rendered in accordance with generally accepted medical practice and professionally recognized standards and within the scope of your applicable license, accreditation, certification and registration;
- Complying with any and all applicable state and/or federal laws related to the delivery of health care services and the confidentiality of Protected Information and taking all precautions to prevent the unauthorized disclosure of such Covered Individuals medical and billing records;
- Complying with PHCS and PHCS Customer requests for copies of a Covered Individual’s medical and billing records for those purposes which PHCS and/or its Customer deem reasonably necessary, including without limitation and subject to any applicable legal restrictions, quality assurance, medical audit, credentialing or recredentialing;
- Cooperating with the Quality Management Programs of PHCS and/or PHCS Payors;

- Meeting the PHCS credentialing criteria, as referred to later in this section; and
- Honesty in all dealings with PHCS, its Customers and Payors. As a Preferred Facility, you agree not to make any untrue statements of fact in any claim for payment, nor any untrue statements of material fact or any intentional misrepresentations of any fact in any statement made to PHCS or any PHCS Payor.

Quality Monitoring Activities

The Quality Management Committee The PHCS Quality Management Committee is a companywide council that provides support and oversight of quality management and improvement activities at PHCS. This integrated support and promotion of quality initiatives is vital to PHCS, and the Committee's objectives, listed below, reflect this:

- To strengthen the position of PHCS as an organization that continually strives to deliver services of optimal quality to its customers and their enrollees;
- To promote companywide awareness of and participation in continuous quality improvement;
- To oversee activities throughout PHCS that contribute to quality and process improvement; and
- To assist PHCS with meeting national accreditation standards, state and federal mandates and customer expectations.

In addition to the Quality Management Committee, the PHCS commitment to quality includes maintaining provider credentialing, recredentialing and Quality Management programs. Specifics of these programs are provided below. For more information on the Quality Management Committee and the Annual Quality Improvement Plan that it develops and oversees, go to www.phcs.com or call the PHCS Provider Relations Department toll-free at (800) 950-7040.

Credentialing

PHCS credentials each acute inpatient facility. PHCS has established and periodically updates credentialing criteria for all categories of providers it accepts into its Network. The credentialing criteria include but are not limited to:

- Accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to a level of "accreditation with type 1 recommendations" or above; or
- Certification by the Centers for Medicare & Medicaid Services (CMS) as a Medicare Participant; or
- Satisfactory completion of the PHCS Request for Information for "Acute Inpatient Facilities;" and
- Professional liability insurance of \$1 million/occurrence and \$5 million in aggregate; and
- General liability insurance of \$1 million/occurrence and \$5 million in aggregate.

The PHCS Credentialing Committee makes all decisions regarding provider participation in the **PHCS Network** in accordance with PHCS credentialing criteria.

Credentialing criteria vary by provider type. To obtain a copy of the PHCS credentialing criteria, please contact the Provider Relations Department at (800) 950-7040.

Recredentialing

PHCS recredentials inpatient acute Preferred Facilities on a set schedule in accordance with state and federal law and national accreditation standards. PHCS reviews JCAHO and CMS databases as appropriate to confirm that accredited or certified status is current. Recredentialing activities may also be triggered as a result of quality management investigations or information received from state or federal agencies.

Quality Management Program

PHCS maintains a Quality Management program that is responsible for the management of complaints originating from various sources, including Covered Individuals, PHCS Payors, the **PHCS Care Management** program and PHCS Payors' Care Management programs.

The Quality Management program acknowledges, tracks and investigates complaints about Preferred Facilities, and manages their resolution through a standard process. Complaints may include but are not limited to perceptions of:

- Unsatisfactory clinical outcome
- Inappropriate, inadequate, over-utilized or excessive treatment
- Unprofessional behavior by Preferred Professional or office staff
- Inappropriate billing practices

As part of your participation in the PHCS Provider Network, you are responsible for participating in, and observing the protocols of the PHCS Quality Management Program. The PHCS Quality Management Program consists of the following:

Investigation Process PHCS facilitates the complaint investigation process by gathering information from various parties (including the Preferred Facility involved) to determine the circumstances surrounding the complaint. Requests for information from Preferred Facilities may include a patient's medical and/or billing records. PHCS recognizes that the Preferred Facility's participation in the investigation process is critical. PHCS will work with the Preferred Facility's risk management department as appropriate. When requesting information, PHCS reports the complainant's concerns and affords the Preferred Facility an opportunity to respond to the complaint.

While complaints are investigated in a timely fashion, it is important to note that timeframes are predicated upon the receipt of information necessary to complete the investigation. Depending upon the nature of the complaint, it may be thirty to sixty (30-60) days before an initial determination is reached. PHCS conducts the investigation process with strict confidentiality. If the complaint is of a clinical nature, PHCS clinical staff (including a PHCS Medical Director) participates in the investigation process.

Outcome of Investigation Investigation outcomes vary based on the type and severity of the complaint and the complaint record of the Preferred Facility. Based upon the outcome, complaints may be categorized as "No Incident," or in levels ranging from "Patient Dissatisfaction" to "Termination."

PHCS communicates investigation outcomes and resulting actions directly to the Preferred Facility involved. If the quality of care rendered at the Preferred Facility is below acceptable standards, PHCS will work with the Preferred Facility to develop a corrective action plan. If the corrective action plan does not result in acceptable standards of care, PHCS may terminate the relationship with the Preferred Facility. If an acute inpatient Preferred Facility is terminated from participation in the PHCS Provider Network, the Preferred Facility will be notified in writing and informed of the right to appeal. All complaint records are maintained confidentially and reviewed during the recredentialing process. Data obtained from analysis of complaint records may also be used in aggregate form to support other initiatives, including provider education.

Appeals Process for Professionals Terminated or Rejected from the PHCS Provider Network PHCS complies with all state and federal mandates with respect to appeals for acute inpatient facilities terminated or rejected from the PHCS Provider Network. Terminated or rejected acute inpatient facilities may submit a request for an appeal as outlined in the letter of rejection/termination sent by PHCS. In addition, the request for appeal must be received by PHCS within thirty (30) days of the date of the rejection/termination letter. Upon receipt of the letter by PHCS, the appeal is forwarded to the PHCS Appeals Committee for review.

The voting members of the Appeals Committee are PHCS Medical Directors and Preferred Professional(s). Advisory members include:

- Appeals Committee Chair-PHCS Medical Director
- One representative from the PHCS Provider Network Quality Department
- One representative from the PHCS Legal Services Division

The appeal is conducted on the basis of any written information submitted by the terminated or rejected provider, in conjunction with any information previously in possession of, or gathered by, PHCS. Unless required by state or federal law, PHCS does not offer meetings in person or by telephone with the terminated or rejected provider, or any representative thereof, as part of the appeals process.

The appeal information submitted by the terminated or rejected provider is presented to the Appeals Committee by either a representative from PHCS Corporate Quality Management or the PHCS Medical Director in whose region the provider practices.

By majority vote, the Appeals Committee renders a decision to uphold or reverse the initial decision to reject or terminate the provider. The acute inpatient facility has the right to request a second level of appeal, which is heard by a separate PHCS Appeals Committee. The determination of the second level Appeals Committee is final.

In the event that PHCS upholds a decision to terminate a provider upon appeal, the original effective date of the termination is upheld unless otherwise determined by the PHCS Appeals Committee.

If the Appeals Committee reverses a termination decision, the Preferred Facility's participating status is reinstated as of the date of the initial adverse decision, unless otherwise determined by the Appeals Committee.

PHCS Participation Requirements

Care Management

Care Management requirements may vary by PHCS Payor, and by the Covered Individual's Contract.

Certification*

Most Care Management programs used by PHCS Payors require Certification. As part of the Certification process, please be prepared to provide the following information by telephone or facsimile, or through any other method of communication acceptable to the PHCS Payor's Care Management or Utilization Review program:

- Payor name
- Group policy number or name
- Policyholder's name, social security number and employer (group name)
- Patient's name, sex, date of birth, address, telephone number and relationship to policyholder
- Preferred Professional's name and specialty, address and telephone number
- Facility name, address and telephone number
- Scheduled date of admission/treatment
- Diagnosis and treatment plan
- Significant clinical indications
- Length of stay requested

Preferred Professionals are required to obtain Certification from the Care Management or Utilization Review program for the following:

• Inpatient admissions, outpatient surgery and other procedures identified by the PHCS Payor's Care Management or Utilization Review program

To obtain Certification for these procedures, call the telephone number provided by the Covered Individual or the PHCS Payor prior to the date of service to the

**For some inpatient and outpatient procedures, Certification is not required; however, notification to the Care Management or Utilization Review program is required. In most cases, a written confirmation of notification will be provided by the Care Management or Utilization Review program.*

Covered Individual. You must obtain separate certifications for multiple surgical procedures. To facilitate a review, be sure to initiate the Certification process a minimum of seven to ten (7-10) days before the date of service. Certifications for inpatient surgical procedures are typically based upon admission on the day of the surgery, unless criteria are met indicating the requirement for an earlier admission, e.g. pre-operative care.

- **Emergency admissions** Certification of all admissions following an emergency room visit is required within forty-eight (48) hours after the admission.
- **Length of stay extensions** In the event a length of stay extension is required for those health care services initially requiring Certification, you are required to obtain additional Certification from the Care Management or Utilization Review program prior to noon of the last certified day.

Notification of Certification Decisions

The PHCS and PHCS Payors' Care Management or Utilization Review programs provide for timely notification of Certification decisions to Covered Individuals, participating professionals, and facilities. Initial notification is made by telephone and is followed by written confirmation.

Case Management

Case management identifies those Covered Individuals whose diagnoses typically require high-level and/or long-term treatment. The case manager conducts an assessment of clinical, environmental and psychosocial factors and considers the location of care. The case manager then works with providers and family members to formulate a plan that efficiently utilizes health care resources to achieve the optimum patient outcome. Case management services are provided for Covered Individuals who may benefit from:

- Change in facility or location of care
- Change in intensity of care
- Arrangements for ancillary services
- Coordination of complex health care services

The PHCS Ancillary Service Provider Network

If the Covered Individual requires laboratory, radiology or home health care services, PHCS has developed an extensive ancillary network consisting of laboratories, radiology service sites and home health care providers. When these types of services are required, PHCS requests that Preferred Providers refer Covered Individuals to an ancillary provider within the **PHCS Network**. For assistance in finding other **PHCS Network** providers for referral purposes, contact the Provider Relations Department toll-free at (800) 950-7040.

Certification is not a Guarantee of Payment

Certifying treatment with the Care Management program does not guarantee payment for services rendered to any Covered Individual. Before completing the Certification process, always contact the PHCS Payor to obtain eligibility information. All Certifications are subject to retrospective review and approval. In cases where multiple procedures are performed, be sure to confirm benefit eligibility from the PHCS Payor for each procedure.

Appeals Process for Care Management Decisions

The appeals process may vary by the Payor's Care Management program and/or as mandated by state or federal law. In the event you or a Covered Individual do not agree with a noncertification determination made under the Care Management program, you or the Covered Individual have the right to appeal the determination in accordance with the PHCS Payor's Care Management program appeals process. To obtain details of the PHCS Payor's Care Management program appeals process, please contact the appropriate PHCS Payor.

Reimbursement and Billing Requirements

Identification of Covered Individuals

PHCS Payors furnish Covered Individuals with a means of identifying themselves as covered under a Contract. Such methods of identification include, but are not limited to, identification cards; affixing the PHCS logo to identification cards; or a telephone number to call for verification of the Covered Individual's eligibility. Always contact the PHCS Payor to obtain eligibility and benefit information before rendering services. Please note that confirmation of eligibility does not guarantee payment. Benefit restrictions may apply. Be sure to notify Covered Individuals of restrictions identified when contacting the PHCS Payor.

Compensation and Claims Submission

Compensation is determined by the terms of the Preferred Facility Agreement agreed upon by the Preferred Facility and PHCS. As a Preferred Facility, you agree to submit to the PHCS Payor (whether primary or secondary) a timely, clean claim for services rendered to Covered Individuals. All claims should be submitted with your regular billing rates using industry standard coding guidelines, including, but not limited to AHA Clinical Coding, the American Medical Association (AMA) and/or Centers for Medicare and Medicaid Services (CMS).

Note: PHCS is not an insurer, guarantor or payor of claims and is not liable for any payment of claims submitted by the Preferred Facility to PHCS or any PHCS Payor.

Submitting Claims by Mail Claims must be submitted to the address found on the Covered Individual's ID card using a UB92 claim form.

Submitting Claims Electronically All claims may be submitted electronically through transaction networks and clearinghouses in a process known as Electronic Data Interchange (EDI). This method promotes faster, more

accurate processing than paper claims submitted by mail, and is required by federal benefit plans. We encourage you to exercise your best efforts to implement electronic claims submission capability as soon as reasonably practicable.

Reimbursement Policies

Administrative/Facility Fees When fees are negotiated for care, treatment and supplies pursuant to the PHCS Preferred Facility Agreement, it is recognized that such services may include an administrative and maintenance component. As a result, the fees paid for health care services pursuant to the PHCS Preferred Facility Agreement include payment for administrative, oversight, overhead and/or similar charges related to the provision of any service rendered. You may not separately bill or collect from the Covered Individual or the PHCS Payor any additional amount for administrative, oversight, overhead and/or similar charges related to the provision of such services.

Coordination of Benefits

Covered Individuals are sometimes covered by more than one insurance policy, benefit plan or other health plan or program. In that instance, the PHCS Payor uses the following rule for the Coordination of Benefits (COB) with regard to payment:

PHCS Payor is Primary When a PHCS Payor is primary under the COB rules, the PHCS Payor pays or arranges to pay for services according to the Covered Individual's Contract (e.g., 90%, 80%, or any other percent) and pursuant to the PHCS negotiated rate.

PHCS Payor is Secondary If a PHCS Payor is secondary under the COB rules, the PHCS Payor pays or arranges to pay for services for only those amounts, which, when added to the amounts paid by all other sources (e.g., primary payor, Covered Individual, or any other party liable for payment) equals one hundred percent (100%) of the PHCS negotiated rate.

As a Preferred Facility, you are required to cooperate fully with PHCS and/or PHCS Payors in supplying information about other entities providing primary medical coverage or otherwise having payment responsibility for services rendered to Covered Individuals, and in all other matters relating to proper coordination of benefits.

Note: Payment may vary based on state or federal law when Medicare is a primary or secondary payor.

Balance Billing

Please be sure to review the Explanation of Benefits (EOB) form sent to you by the PHCS Payor to determine the amount billable to the Covered Individual. At the time of the visit, you may collect any copayment or encounter fee specified in the Covered Individual's Contract. Following the receipt of an EOB, you may bill for deductibles and co-insurance, if any, as specified in the Covered Individual's Contract, and/or payment for non-covered care.

As specified in the PHCS Preferred Facility Agreement, Covered Individuals cannot be billed for the difference between your total billed charges and the PHCS negotiated rate.

Benefit Maximums

As previously mentioned, Covered Individuals cannot be billed for the difference between regular billing rates and the PHCS negotiated rate for Covered Care, whether the payor is primary or secondary. In instances where the cumulative payment by a PHCS Payor has met or exceeded an annual or lifetime benefit maximum for a particular type of Covered Care rendered to a Covered Individual, which limits the PHCS Payor's cumulative responsibility for payment of a select set of services to some annual or lifetime dollar amount or service count, Preferred Providers may not "balance bill" Covered Individuals for the difference in regular billing rates and PHCS negotiated rates. This prohibition will remain in effect as long as the patient remains a Covered Individual under a PHCS Contract.

When a particular type of care, treatment or supply is considered to be a "major medical exclusion" pursuant to the Contract and/or does not qualify under any circumstance as Covered Care for the Covered Individual, Preferred Providers may bill the Covered Individual at the regular billing rate for the "excluded" service.

Assignment of Benefits and Release of Medical Information

PHCS Payors can pay or arrange to pay Preferred Facilities directly only when the Covered Individual has approved the assignment of benefits. You may obtain an assignment using your standard form. Signatures need only be provided once and can be filed with the Covered Individual's record. All claims submitted should indicate that signatures for assignment of benefits are "on file."

For some types of treatment, PHCS Payors may require the Covered Individual's consent (and possibly the consent of family members) to release Protected Information. These signatures should be kept on file with the Covered Individual's record.

Reimbursement for the Duplication of Medical Records

If copies of medical records are requested to process an admission, concurrent review, appeal or retrospective review, you will be reimbursed the cost of medical record duplication at the Medicare rate then in effect unless otherwise provided for by contract or law.

Enrollee Rights and Confidentiality

PHCS Statement of Enrollee Rights

PHCS has adopted a statement recognizing enrollee rights and protections. PHCS expects that you will support and act in accordance with these rights. For a copy of the PHCS Statement of Enrollee Rights, go to www.phcs.com or call the PHCS Provider Relations Department toll free at (800) 950-7040.

PHCS Policies Regarding Enrollee Confidentiality and Privacy

- Enrollee-specific confidential information includes, but is not limited to: name, PHCS or payor-unique identifiers, date of birth, address, phone number, social security number, employer/policy number, place of hospitalization or treatment, and the information contained within medical or behavioral health records that is necessary for conducting PHCS business.
- PHCS Customers that enroll subscribers may obtain the enrollee's routine consent at the time of enrollment. Such routine consent covers future, known or routine needs for the use of personal health information, such as: treatment, coordination of care, quality assessment and measurement, accreditation and billing/claims payment. Enrollee-specific information obtained by PHCS during Care Management and provider quality management processes constitutes such a routine use, and is used solely for the purposes of Care Management, Quality Management, discharge planning and care management.
- PHCS contractually requires independent providers to maintain the confidentiality of enrollee information and medical records. It is PHCS policy that enrollees have the right to information contained in their medical records. If an enrollee requests access to his/her medical records, PHCS staff will direct him/her to contact the provider.

- Enrollee-specific information is shared on a need-to-know basis. PHCS employees and consultants/vendors are bound by the employee confidentiality policy signed at the point of employment, and are expected to exercise sound judgment in collecting, handling, storing, communicating and retrieving any enrollee-specific information.
- Enrollee-specific information collected by PHCS is limited to that which is necessary to perform the task required. All enrollee-specific information collected and handled by PHCS staff is secured in private areas with controlled access.
- Enrollee-specific information is not released to a non-provider caller, who is not a PHCS Customer or PHCS Payor, without written consent from the enrollee or designee or upon court order or as otherwise required by law (e.g., state requirements regarding behavioral health services). PHCS makes its best effort to protect enrollee-specific information when communicating with Customers and Payors. Customers and Payors are expected to protect such information from misuse.
- When enrollee-specific information is shared outside PHCS with a contractor or for purposes of conducting PHCS business as described above, the organization receiving the information is expected to protect the data according to PHCS specifications. Information shared with outside parties for purposes of conducting PHCS business is rendered anonymous whenever possible.
- PHCS responds to requests for clinical records, including but not limited to subpoenas, in compliance with state and federal law regarding such records.
- An enrollee's HIV status or AIDS diagnosis is never requested, discussed or documented by PHCS. A reference to immune status is acceptable.

Section Five

- Enrollees who feel their confidentiality has been breached may avail themselves of the PHCS complaint resolution process. To initiate a complaint, the enrollee should document the complaint in writing and send it to:

Private Healthcare Systems

1100 Winter Street

Waltham, MA 02451-1227

Attn: Corporate Quality Management Department

Enrollees may also send the documented complaint via e-mail to cqm@phcs.com.



Private Healthcare Systems

1100 Winter Street

Waltham, MA 02451

(800) 950-7040

www.phcs.com

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