

AUTHORIZATIONS



South Carolina

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DISCLAIMER

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AGENDA

- Overview of Authorizations
- Process of Authorizations
- Authorization Vendors
- Resources



AUTHORIZATIONS OVERVIEW



WHAT YOU NEED TO KNOW ABOUT AUTHORIZATIONS

Authorizations are used to determine whether a service is medically necessary.

Authorization requirements can vary per plan and network.

Authorizations do not guarantee payment.

COMMON SERVICES THAT REQUIRE AUTHORIZATION

Elective inpatient services (including maternity)

Skilled nursing facility admission

Home health and hospice

Durable medical equipment (DME)*

Mental health and substance abuse

High tech imaging**

Certain medications under the medical benefit

* DME dollar thresholds vary per plan but are typically \$500 or \$1,000. The threshold amounts can be lower than \$500

** These services are typically handled by Evolent.

GENERAL GUIDELINES FOR AUTHORIZATIONS

Submit elective requests prior to rendering services.

Mark requests as urgent **only** when they are urgent.

Submit a notification of emergency admission within 24-48 hours of admission.

Members must have active coverage at the time of request.

Submit requests once.

Services must be covered under the member's plan.



MAIN STEPS IN THE AUTHORIZATION PROCESS

Verify the member's benefits and provider network.

If authorization is required, initiate the request.

Receive a decision (Approval or denial).

REQUIRED INFORMATION FOR AUTHORIZATIONS

Patient Details

- Name
- ID number
- Date of birth

Service Details

- CPT or HCPCS codes
- Diagnosis codes
- Date of service

Location Details

- Facility
 - Name
 - Address
 - Tax ID or NPI
- Rendering
 - Name
 - Address
 - Tax ID or NPI

Contact Information

- Phone number
- Fax number
- Email

Clinicals

- Length of issue
- Attempted treatment
- Conservative medications
- Studies (i.e., labs, imaging)



PROCESS FOR AUTHORIZATIONS



HOW TO GET AN AUTHORIZATION

- There is a single sign-on through My Insurance ManagerSM.
- Under *Patient Care*, select *Pre-certification/Referral*.

Health

- | | |
|-----------------------------|--|
| ▶ Authorization Extension | ▶ Patient Directory |
| ▶ Authorization Status | ▶ Pre-Certification/Referral |
| ▶ Claims Status | ▶ Superbill Maintenance |
| ▶ Eligibility and Benefits | ▶ Pre-Service Review for Out-of-Area Members |
| ▶ Institutional Claim Entry | ▶ Professional Claim Entry |
| ▶ Other Health Insurance | ▶ Verify Primary Care Physician |

Dental

- | | |
|----------------------------|---------------------------------|
| ▶ Claims Status | ▶ Patient Directory |
| ▶ Dental Claim Entry | ▶ Superbill Maintenance |
| ▶ Eligibility and Benefits | ▶ Pre-Treatment Estimate Entry |
| ▶ Other Dental Insurance | ▶ Pre-Treatment Estimate Status |

COHERE HEALTH – LANDING PAGE

- When you reach the landing page of the new platform, you will see a full listing of authorizations under your tax identification number (TIN).
- The authorizations can be filtered by:
 - All
 - Upcoming
 - Pending review
 - Approved
 - Denied
 - Draft
 - Withdrawn
 - Completed
- You can also search for a specific patient or authorization.
- To start a new request, select ***Start auth request***.

The screenshot displays the Cohere Health landing page for a user associated with BCBS South Carolina. The page features a navigation bar with the BCBS South Carolina logo, the text "powered by Cohere Health", and links for "Support" and "My account". Below the navigation bar, there is a search bar labeled "Search (Patient name, Member ID, Auth ID)" and a "Start auth request" button. A "Filter by user" dropdown is also present. The main content area shows a list of authorizations for a patient named John Doe, sorted by "Most recent". Each authorization entry includes the patient's name, DOB (01/26/1965), Member ID (1019152022), Health plan (BCBS South Carolina), Services, Procedure codes, Submission date, and Dates of service. The first two entries are "Approved" and include a "Start continuation" link. The third entry is a "Draft" and includes "Delete" and "Continue" links. The fourth entry is partially visible at the bottom of the screen.

Patient Name	DOB	Member ID	Health Plan	Services	Procedure Codes	Submission Date	Dates of Service	Status	Actions
Doe, John	01/26/1965	1019152022	BCBS South Carolina	Physical Therapy, Speech Therapy	97110, 97112, 92507	05/15/2024 3:45 PM	06/15/2024 – 09/30/2024	Approved	Start continuation
Doe, John	01/26/1965	1019152022	BCBS South Carolina	Myocardial Perfusion Imaging Single Photon Emission Computed Tomography (MPI-SPECT),...	78451, 78452, 93015	05/15/2024 3:45 PM	06/15/2024 – 09/30/2024	Approved	Start continuation
Doe, John	01/26/1965	1019152022	BCBS South Carolina	Physical Therapy	97110	--	12/01/2022 – 03/01/2023	Draft	Delete Continue
Doe, Jane	01/26/1965	1019152022	BCBS South Carolina	Physical Therapy	97110, 97112, 97114	12/01/2022	12/01/2022 – 04/01/2023		

COHERE HEALTH – PATIENT SEARCH

- Enter the member's ID number.
- Enter the member's date of birth.
- Select ***Start auth request*** next to the appropriate member in the results.

The screenshot shows a 'Patient search' form with two input fields: 'Health plan member ID' containing 'H91001351' and 'Member date of birth (MM/DD/YYYY)' containing '07/11/1982'. A teal 'Search' button is positioned below the fields. The results section, titled '1 RESULT', displays a patient entry for 'Shar Humi' with a 'Patient summary' link and a 'Start auth request' button.

Patient search
Find a patient: all information required.

Health plan member ID
H91001351

Member date of birth (MM/DD/YYYY)
07/11/1982

Search

1 RESULT

Shar
Humi

[Patient summary](#)

[Start auth request](#)

COHERE HEALTH – PRIMARY DETAILS

- Select whether the service is outpatient or inpatient.
- Include the diagnosis and procedure code(s).
- Select *Continue*.

The screenshot shows a web form titled "Tell us about your request" for a patient named John Doe (DOB: 09/16/1986) at South Carolina, powered by Cohere Health. The form includes the following sections:

- Request details:** Radio buttons for "Outpatient" (selected) and "Inpatient". A "Start date" field is set to 06/01/2024.
- Diagnosis codes:** A "Primary diagnosis code" field contains M48.06. A "Search for secondary diagnosis codes (optional)" field is empty.
- Procedure codes:** A "CPT/HCPCS codes" field contains 63047.

At the bottom of the form, there are three buttons: "Save and exit", "Cancel", and "Continue".

Note: You have the option to save and exit the request at any time. You can also cancel the request if it's no longer needed.

COHERE HEALTH – PROVIDER DETAILS

- Enter the provider details to include:
 - Ordering provider.
 - Performing or attending provider.
 - Performing facility or agency.
- There is a TIN search feature to make the process easier.
- Select ***Continue***.

The screenshot shows a web form titled "Providers" with the following sections:

- Care setting:** Radio buttons for "Outpatient" (selected) and "Inpatient".
- Place of service:** A dropdown menu.
- Ordering provider:** A search box with the placeholder "Search for an ordering provider by NPI, TIN, or name" and a magnifying glass icon. To the right are buttons for "TIN" and "Address". A blue pill-shaped button below the search box contains "+ Bailey, Christopher Eric MD".
- Performing or attending provider:** A checkbox labeled "Performing is the same as the ordering" is unchecked. Below it is a search box with the placeholder "Search for a performing or attending provider by NPI, TIN, or name" and a magnifying glass icon. To the right are buttons for "TIN" and "Address". A blue pill-shaped button below the search box contains "+ Bailey, Christopher Eric MD".
- Performing facility or agency:** A search box with the placeholder "Search for a performing facility or agency by NPI, TIN, or name" and a magnifying glass icon. To the right are buttons for "TIN" and "Address". A blue pill-shaped button below the search box contains "+ 1ST START HEALTHCARE SERVICES".

At the bottom of the form, there is a blue button labeled "Save and exit".

COHERE HEALTH – RESULTS

- On this screen, the top portion will tell you which codes you requested require authorization.
- The bottom portion will tell you which codes do not require authorization.
- There's an option to expedite the request if it's an ***urgent matter***.
- Select ***Continue***.

The screenshot displays a web interface for managing authorization requests. At the top, a green checkmark icon is followed by the text "Requires authorization". Below this, there are two date input fields: "Start date" with the value "04/30/2024" and "End date" with the placeholder "mm/dd/yyyy".

The first section is titled "Physical Therapy (PT)". It contains a "Number of visits" input field with the value "1". Below this is a procedure code "97110" with a description: "Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility". There is an "Add a procedure code" button below the code.

The second section is titled "Total Knee Arthroplasty (TKA)". It features a procedure code "27447" with a "Units" input field set to "1". The description is "Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)". A "Remove" button is located to the right of the code. Below this is another "Add a procedure code" button.

At the bottom of the main form area, there is an "Expedite" checkbox which is currently unchecked.

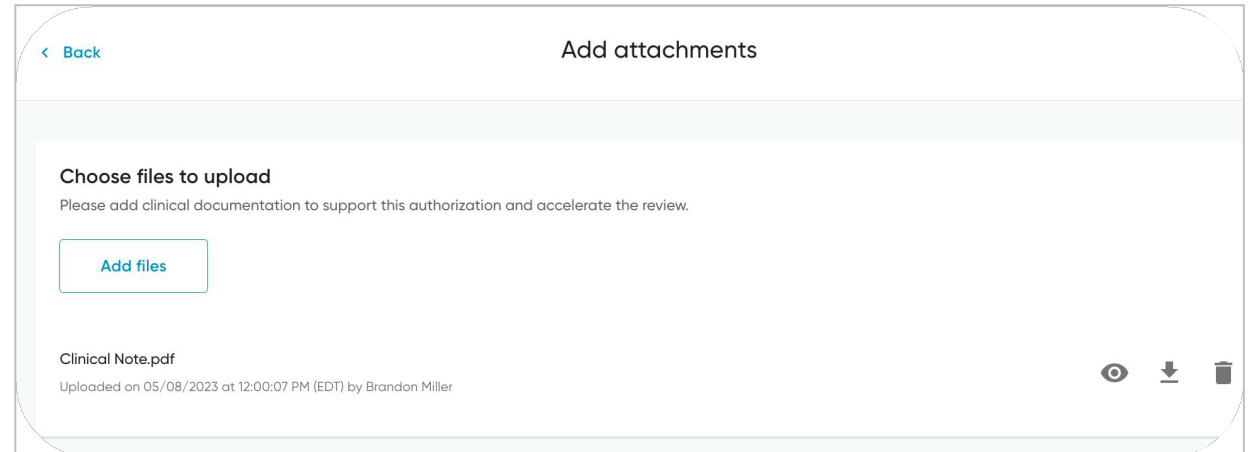
Below the main form, there is a section with an information icon and the text "Doesn't require authorization in most cases". Below this text is a procedure code "93798". To the right of this section is a "Download PDF" button with a dropdown arrow.

At the very bottom of the interface, there are two buttons: "Save and exit" on the left and "Continue with 2 codes" on the right.

Note: The continue option will indicate the number of codes being requested for review.

COHERE HEALTH – CLINICAL DOCUMENTATION

- Upload all relevant clinical documentation for review.
- You will have the option to review the uploaded items or remove them.
- Select *Continue*.



COHERE HEALTH – SUBMIT REQUEST

- Review all the relevant information.
 - The orange box displays if there is a possible duplicate request on file. Review the current authorizations (whether approved or pending) to avoid submitting an unnecessary duplicate request that would eventually be voided.
 - The purple box displays if there is an expedited request, but based on the services and clinicals, there's no evidence supporting the need for it to be expedited. The provider will be asked to consider changing the request to “not expedited” by selecting Accept. If not, they can continue with the expedited request.
- Select ***Submit services***.

Back Review services before submitting

Physical Therapy (PT), Total Knee Arthroplasty (TKA)

This request duplicates an existing one
Duplicate submissions may be voided. The care setting (outpatient or inpatient), performing provider (if applicable), and facility match an existing request, including overlap in procedure codes and service dates.

You can choose to withdraw the existing request, change details to avoid duplication, or call Cohere for assistance at (833) 283-0033.

Draft Tracking #WKGB4665 Delete

Details Edit

Primary diagnosis	M25.561 - Pain in right knee
Secondary diagnosis	--
Care setting	Outpatient
Place of service	Ambulatory Surgical Center

Save and exit Submit services

1 evidence-based suggestion to improve your request:

Expedited → Not expedited
The coverage and/or services on this request do not meet the requirements for an expedited request. Accept

COHERE HEALTH - NOTIFICATIONS

- You will be notified once the authorization is approved or denied.
- To view additional details, select ***View service summary*** inside the portal.



South Carolina

powered by **Co**here Health

Your request has been approved

Tracking #: **NPOA6057**

Dates of service: **06/01/2024 – 09/30/2024**



Hello <user's name>,

Thank you for submitting a service request with Cohere Health. We have reviewed your request and it has been approved. More information about this decision (including the authorization number) is available in the service summary.

[View service summary](#)

COHERE HEALTH – SERVICE SUMMARY

- The **service summary** will outline the requested authorization to include:
 - Diagnosis and procedure code(s).
 - Place of service.
 - Ordering provider.
 - Performing or attending provider.
 - Performing facility or agency.
 - Dates of service.

 South Carolina | powered by  Cohere Health

Questions about this service?
Contact BCBS South Carolina
(000) 000-0000

Service summary

Created on 05/01/2024

Diagnosis
M48.06 - Spinal stenosis, lumbar region without neurogenic claudication

Service
Spinal Fusion and Decompression

Code	Status	Description
63047	1 unit approved	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

Dates of service 06/01/2024 – 09/30/2024	Type Outpatient
Member ID 10119152022	Ordering provider Bailey, Christopher Eric MD / NPI - 1861781510
Patient name Doe, John	Performing or attending provider Bailey, Christopher Eric MD / NPI - 1861781510
Patient phone number (617) 283-4909	Performing facility or agency Peachtree Orthopaedic Surgery Center / NPI - 1902861941
Patient date of birth 01/26/1965	Facility state Georgia
	Authorization number BCBS South Carolina - NPOA6057

COHERE HEALTH – PATIENT SUMMARY

- The *patient summary* will outline the same details as the service summary but will give you the option to view the clinical documentation that was provided.

The screenshot displays a patient summary page for John Doe (Member ID 10119152022). The page is titled "Patient summary" and includes a "Start auth request" button. The patient's personal information is listed on the left, including sex (Male), DOB (01/26/1965), age (59), address (420 Harvard St. #301 Brookline, MA), phone ((617) 283-4909), preferred written language (English), PCP grouper ID (918401720), plan (BCBS South Carolina Commercial), membership type (Commercial), plan type (HMO), and plan year (04/24/2024 - 04/24/2025).

The main content area shows a summary of a "Spinal Fusion and Decompression" procedure, which is marked as "Approved" with authorization #NPOA6057 and tracking #NPOA6057. The details section lists the primary diagnosis as "M48.06 - Spinal stenosis, lumbar region without neurogenic claudication" and provides information on secondary diagnosis, care setting (Outpatient), place of service (Ambulatory Surgical Center), ordering provider (Bailey, Christopher Eric MD / NPI - 1861781510), performing or attending provider (Bailey, Christopher Eric MD / NPI - 1861781510), performing facility or agency (Peachtree Orthopaedic Surgery Center / NPI - 1902861941), dates of service (06/01/2024 - 09/30/2024), and expedited status (No).

The procedure details are summarized in a table:

Code	Status	Description
63047	1 unit approved	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar

There is one attachment titled "DoeJohn_ClinicalNote.pdf", uploaded on 05/01/2024 02:39:51 PM (EST) by Connor Feick. A "Show clinical assessment" link is available below the attachment. The page also shows the request was made by Connor Feick - Portal and includes a "Withdraw" button.



AUTHORIZATION PARTNERS



ORGANIZATIONS THAT MANAGE SELECT AUTHORIZATIONS

- Evolent
- Avalon Healthcare Solutions
- Specialty Pharmacy Manager (MBMNow)
- Companion Benefit Alternatives (CBA)
- Integrated Home Care Services (IHCS)

Note: These are independent organizations that offer utilization management on behalf of BlueCross and BlueChoice.

EVOLENT

- Manages the following types of authorization for most plans:
 - Radiation oncology
 - Advanced radiology
 - Musculoskeletal care (MSK)
- To request an authorization:
 - Use: My Insurance Manager or visit www.RadMD.com
 - Call: 866-500-7664 for BlueCross members
 - Call: 888-642-9181 for BlueChoice® members



AVALON HEALTHCARE SOLUTIONS

- Manages authorizations for lab services in the following settings:
 - Office
 - Outpatient facility
 - Independent laboratory
- To request an authorization:
 - My Insurance Manager
 - Use the Prior Authorization System (PAS)
 - Call: 844-227-5769
 - Fax: 813-751-3760
 - Fax form located on www.SouthCarolinaBlues.com:
 - Providers>Policies and Authorizations>Prior Authorization>Laboratory Medical Benefits



Note: Avalon does not review requests in an emergency room, ambulatory surgery center or inpatient hospital setting.

MBMNOW (SPECIALTY PHARMACY)

- Manages authorizations for certain specialty medications.
 - View the available lists on www.SouthCarolinaBlues.com.
 - Providers>Specialty and Pharmacy Drugs>Specialty Medical Medications
- To request an authorization:
 - Access MBMNow through My Insurance Manager
 - Call: 877-440-0089
 - Fax: 612-367-0742



BlueCross BlueShield of South Carolina

COMPANION BENEFIT ALTERNATIVES

- Manages authorizations for behavioral health services.
 - Examples of services include:
 - Psychological testing
 - Behavioral health program admissions
 - Repetitive transcranial magnetic stimulation (rTMS)
- To request an authorization:
 - Visit www.CompanionBenefitAlternatives.com.
 - Call: 800-868-1032



INTEGRATED HOME CARE SERVICES

- Manages certain authorizations for Medicare Advantage and Group and Individual plans.
- For Medicare Advantage:
 - DME in the home setting
 - Home health
 - Home infusion services
- For Group and Individual
 - DME
 - Home health
- To request an authorization:
 - Call: 844-215-4264
 - Fax: 844-215-4265
 - Include the appropriate fax form





AUTHORIZATION RESOURCES



STANDARD PRIOR AUTHORIZATION LIST

- BlueCross developed a standard prior authorization list.
 - www.SouthCarolinaBlues.com
 - Providers>Policies and Authorizations>Prior Authorization
- The list only applies to the following lines of business:
 - National Alliance
 - Major Group
 - Small Group and Individual
 - Planned Administrators Inc.
 - State Health Plan
- **The list is not all inclusive and is subject to change. It's a guide that includes the most requested services that require medical review for prior authorizations.**



SERVICES THAT REQUIRE PRIOR AUTHORIZATION STANDARD LIST EFFECTIVE OCTOBER 2025

Many of our plans require prior authorization for certain procedures and services. This process allows us to check ahead of time whether services meet criteria for coverage by a member's health plan. Some services on this list may not be covered by the benefit plan. **Always verify benefits prior to services being rendered.**

Prior authorization is not a guarantee of payment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied.

This list is not all inclusive and is subject to change. It is a guide that includes the most commonly requested services requiring a medical review. Other services may require review based on our medical policies, guidelines or the employer group's plan of benefits. **Please review specific contract verbiage for exclusions, limitations and/or maximums.**

List does not apply to medical specialty drugs. To find out which medical specialty drugs require prior authorization under the medical plan or the Specialty Medical Benefit Management (SMBM) program, refer to My Insurance Manager™.

Some plans may require prior authorization for mental health services. Contact Companion Benefit Alternatives (CBA) to verify by calling 800-868-1032. CBA is a wholly owned subsidiary of Blue Cross Blue Shield.

Online Resources and Tools

www.CompanionBenefitAlternatives.com

<https://www.bcbs.com/blue-distinction-center/facility>

- Medical Policies
- Prior Authorization Forms and Information
- Clinical Form Resource Center
- Blue Distinction Center Facility Finder

Inpatient

- Elective, nonemergent inpatient (surgical or nonsurgical) hospital admissions (medical and behavioral health)
- Acute rehabilitation admissions
- Hospice
- Long term acute care (LTAC) facility admissions
- Skilled nursing facility (SNF) admissions
- Residential Treatment Center (RTC) admissions

AUTHORIZATION RESOURCES

Plan or Vendor	Authorization Service	Web-based Requests	Telephone Requests	Fax Requests
BlueCross	[various]	My Insurance Manager	800-334-7287	
BlueChoice	[various]	My Insurance Manager	800-950-5387	
FEP	[various]	My Insurance Manager	800-327-3238	
State Health Plan	[various]	My Insurance Manager	800-925-9724	
Avalon	Laboratory	My Insurance Manager	844-227-5769	813-751-3760
CBA	<ul style="list-style-type: none"> • Behavioral health • Substance abuse 	My Insurance Manager or www.CompanionBenefitAlternatives.com	800-868-1032	
Evolut	<ul style="list-style-type: none"> • Advanced Radiology • Musculoskeletal Care • Radiation Oncology 	My Insurance Manager or www.RadMD.com	BlueCross: 866-500-7664 BlueChoice: 888-642-9181	888-656-1321
MBMNow	Specialty Medical Drug	My Insurance Manager	877-440-0089	612-367-0742
IHCS	<ul style="list-style-type: none"> • DME, home health and home infusion 		844-215-4264	844-215-4265
Cohere Health	*Platform for medical authorization requests.	My Insurance Manager	888-787-0309	

OUT-OF-STATE MEMBER AUTHORIZATIONS

Use the BlueCard Authorization/Medical Policy tool to verify authorization requirements for out-of-state members.

Providers Providers

[Home](#) / [Providers](#) / [Policies and Authorizations](#) / [Prior Authorization](#) / [BlueCard Prior Authorization/Medical Policies](#)

BlueCard Prior Authorization/Medical Policies

Need prior authorization for a patient who is a member of another Blue plan? If prior authorization is required, you can initiate the process through [My Insurance Manager](#)SM. Once you've logged in, go to Patient Care. Then select "Pre-Service Review for Out-of-Area Members" from the menu.

To view an out-of-area Blue Plan's medical policy or general prior authorization information, please select the type of information you need, enter the first three letters of the identification number on the member's Blue Cross and/or Blue Shield card, and click Submit.

Type of Information

Please select only one.

Medical Policy

General Precertification/Preauthorization Information

This field is required.

Alpha Prefix

This field is required.

If you experience difficulties or need additional information, please contact 800-676-BLUE.

Routes you to the member's Home plan.

OUT-OF-STATE MEMBER AUTHORIZATIONS (CONTINUED)

Example

BlueCard Prior Authorization/Medical Policies

Need prior authorization for a patient who is a member of another Blue plan? If prior authorization is required, you can initiate a [ManagerSM](#). Once you've logged in, go to Patient Care. Then select "Pre-Service Review for Out-of-Area Members" from the

To view an out-of-area Blue Plan's medical policy or general prior authorization information, please select the type of information, enter the first three letters of the identification number on the member's Blue Cross and/or Blue Shield card, and click Submit.

Type of Information

Please select only one.

- Medical Policy
- General Precertification/Preauthorization Information

Alpha Prefix

YPP

Submit

If you experience difficulties or need additional information, please contact 800-676-BLUE.

The screenshot shows the Blue Cross NC website interface. The top navigation bar includes the Blue Cross NC logo, and links for Shop Plans, Members, Providers, Employers, Agents, Contact Us, and a Log In button. The breadcrumb trail reads: Home > Providers > Prior authorization > Prior plan approval. The main heading is 'PROVIDERS' followed by 'Prior plan approval'. The content area explains that prior review (prior plan approval, prior authorization, prospective review or certification) is the process Blue Cross NC uses to review the provision of certain behavioral health, medical services and medications against health care management guidelines prior to the services being provided. It lists examples of services and procedures received on an outpatient basis, such as in a doctor's office, and prescription medications that may be subject to prior review. It also states that users can search for [services and durable medical equipment](#), or [medications](#) that require authorization for all places of service, including when performed during any inpatient admission, including both planned inpatient admissions and emergent inpatient admissions.¹ Below this, it lists 'Reviews may confirm:' followed by a bulleted list: Member eligibility, Benefit coverage, Compliance with Blue Cross NC corporate and Blue Medicare medical policies regarding medical necessity, Appropriateness of setting, Requirements for use of in-network and out-of-network facilities and professionals, and Identification of comorbidities and other problems requiring specific discharge needs.

PEER-TO-PEER REQUESTS

- Process to review and discuss denied prior authorizations.
 - Must be requested before submitting claims.
- Required criteria:
 - Medical necessity adverse decision was received, along with health plan denial
 - Requested within two business days of the denial for inpatient or continued stay requests OR five business days for all other denials
 - Requested prior to an authorization
- Clinical discussion:
 - Facilitated within one business day of receipt of request
 - Our medical doctor makes two attempt to contact the rendering provider
 - A decision is rendered at the end of the call

HOW TO REQUEST A PEER-TO-PEER

Initiating Requests and Checking Statuses

South Carolina Website

- Visit www.SouthCarolinaBlues.com
Providers>Forms>Other Forms>Peer-to-Peer Request
- Enter all pertinent details (and save the document)
- Email the form to Peer.Medical@bcbssc.com or fax to 803-264-9175

Phone (for statuses and eligibility only)

- Call 803-264-8114
Available Monday - Friday
8:30 a.m. – 5:00 p.m. EST

UTILIZATION MANAGEMENT COURTESY RE-EVALUATIONS

- Utilization management courtesy re-evaluations are permitted for denials that are due to the following:
 - No clinical information submitted
 - Insufficient clinical information submitted
- To request a courtesy review, you must:
 - Specify the request is for a re-evaluation upon submission (via fax)
 - Submit clinical documentation within five business days of the denial notice



THANK YOU

