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and posted online. Please visit https://providers.amerigroup.com/FL for the most up-to-date
information.
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1 INTRODUCTION

Welcome to the Florida Statewide Medicaid Managed Care Long-Term Care (SMMC-LTC) provider network family. We are pleased you joined our network, which represents some of the finest providers in the country.

We bring the best expertise available nationally to operate local community-based health care plans with experienced local staff to complement our operations. We are committed to helping you provide quality care and services to our members.

We believe providers are the most critical elements in the success of our health plans. We can only be effective in caring for members by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, quality provider network.
2 OVERVIEW

Who Is Amerigroup?
Amerigroup is a wholly owned subsidiary of Anthem. As a leader in managed health care services for the public sector, we provide health care coverage exclusively to low-income families and people with disabilities. We participate in Medicaid, Florida Healthy Kids and the SMMC-LTC program.

Mission
The Amerigroup mission is to provide real solutions for members who need a little help by making the health care system work better while keeping it more affordable for taxpayers.

The SMMC-LTC program is designed for older and adult disabled members who need help to remain at home or live in a facility. The program focuses on long-term care needs and provides help for individuals who need assistance in their daily living activities such as dressing, housekeeping and bathing.

Strategy
Our strategy is to:
• Encourage stable, long-term relationships between providers and members
• Commit to community-based enterprises and community outreach
• Facilitate integration of physical, behavioral and long-term care
• Provide a full continuum of resources and promote continuity of care for our members
• Foster quality improvement mechanisms that actively involve providers in re-engineering health care delivery
• Encourage a customer service orientation

Summary
The Florida legislature created a new program called Statewide Medicaid Managed Care (SMMC). As a result, the Agency for Healthcare Administration (AHCA) has changed how some individuals receive health care from the Florida Medicaid program.

Two components make up the SMMC program:
• The Florida Long-Term Care (LTC) Managed Care program
• The Florida Managed Medical Assistance (MMA) program

The goals of the MMA program are to provide:
• Coordinated health care across different health care settings.
• A choice of the best-managed care plans to meet recipients’ needs.
• The ability for health care plans to offer different, or more, services.
• The opportunity for recipients to become more involved in their health care.

The goals of the LTC program are to:
• Provide coordinated LTC services to members across different residential living settings.
• Enable members to remain in their homes through the provision of home-based services or in alternative placement, such as assisted living facilities.
The MMA program was implemented in all Florida regions as of August 1, 2014. These changes are not due to national health care reform or the Affordable Care Act. Medicaid recipients who qualify and are enrolled in the MMA program will receive all health care services other than long-term care through a managed care plan.
3 QUICK REFERENCE INFORMATION

Please call us for program information, claims information, inquiries and recommendations you have about improving our processes and managed care program.

Amerigroup Long-term Care Numbers
- Provider Services: 1-877-440-3738
  - Claims inquiry line
  - Case management services
  - Provider Relations
- Electronic Data Interchange hotline: 1-800-590-5745

Availity Web Portal Client Services
- Available Monday through Friday, 8 a.m.-7 p.m. Eastern time at 1-800-AVAILITY (1-800-282-4548) excluding holidays
- Email questions to support@availity.com

Our provider website includes forms and general information about claims payment, member eligibility, and credentialing and recredentialing. Visit our website at https://providers.amerigroup.com/FL.

Note: We do not cover or arrange for acute care services that are covered by Medicare or Medicaid such as physician office visits or hospital services; however, we do provide coverage for services in addition to Medicare covered services, sometimes called wraparound services, such as Medicare, coinsurance and deductibles. Amerigroup case management is responsible for the integration and coordination of Medicare and Medicaid covered services. Medicare and/or Medicaid should be billed for Medicare covered services and/or Medicaid acute care covered services, while Amerigroup should be billed for wraparound and long-term care services.
4 RESPONSIBILITIES OF THE PROVIDER

The provider shall:
- Practice in his or her profession ethically and legally, provide all services in a culturally competent manner, accommodate those with disabilities, and not discriminate against anyone based on his or her health status
- Participate and cooperate with Amerigroup in quality management, utilization review, continuing education and other similar programs established by Amerigroup
- Participate in and cooperate with our grievance procedures when we notify the provider of any member complaints or grievances
- Not balance bill a member
- Comply with all applicable federal and state laws regarding the confidentiality of member records
- Support and cooperate with the Amerigroup Quality Management program to provide quality care in a responsible and cost-effective manner
- Treat all members with respect and dignity, provide them with appropriate privacy, and treat member disclosures and records confidentially to give members the opportunity to approve or refuse their release
- Maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide quality member care
- Contact an Amerigroup case manager if a member exhibits a significant change, is hospitalized or is admitted to a hospice program

All facility-based providers and home health agencies shall provide notice to an Amerigroup case manager within 24 hours when a member dies, leaves or moves to a new residence.

Amerigroup will delegate submission of the DCF #2506A Form to the nursing facilities. Nursing facilities should provide the designated Amerigroup case manager with a copy of the completed form once it has been submitted to DCF.

Assisted living facilities and nursing homes must retain a copy of the member’s Amerigroup plan of care on file. Assisted living facilities are required to promote and maintain a homelike environment and facilitate community integration. Members residing in assisted living facilities and adult family care homes must be offered services with the following options unless medical, physical or cognitive impairments restrict or limit exercise of these options:
- Choice of:
  o Private or semi-private rooms
  o Roommate for semi-private rooms
  o Locking door to living unit
  o Access to telephone and length of use
  o Eating schedule
  o Participation in facility and community activities
- Ability to have unlimited visitation and snacks as desired
- Ability to prepare snacks as desired and maintain personal sleeping schedule
If a provider is unable to provide covered services on the specific date agreed upon with the case manager, the provider must contact the case manager to schedule a new date immediately. If the case manager is not contacted in a timely manner, it may delay adjudication of the claim. All Florida Statewide Medicaid Managed Care Long-term Care (SMMC-LTC) services covered by Amerigroup must be authorized by an Amerigroup case manager.

Providers must complete a Level 2 criminal history background screening to determine whether their subcontractors or any employees or volunteers of their subcontractors who meet the definition of direct service provider have disqualifying offenses as provided for in s. 430.0402 F.S. as created and s. 435.04, F.S. Any subcontractor, employee or volunteer of a subcontractor meeting the definition of a direct service provider who has a disqualifying offense is prohibited from providing services to the elderly as set forth in s. 430.0402, F.S.

Each provider must sign an affidavit attesting to his or her compliance with this requirement. We will keep the affidavit as part of the provider’s credentialing files.

Provider Service Training
All direct service providers are required to attend and complete abuse, neglect and exploitation training. This training can be given by the Department of Children and Families, the local area agency on aging, the Agency for Health Care Administration (AHCA), or training can be accommodated through licensing requirements. Amerigroup training materials are approved in advance by AHCA.

Provider Support Services
We recognize that, to provide quality service to our members, you need the most accurate, up-to-date information. We offer online resource information through our provider website at https://providers.amerigroup.com/FL or the provider inquiry line, an automated telephonic system at 1-877-440-3738. These tools allow you to verify member eligibility and claim status. All you need is one of the following:
- Member ID number
- Member Medicaid number
- Member Social Security number

Concerns, Suggestions and Complaints
We have assigned a Provider Relations representative to help you with the administration related to providing services to Amerigroup members. Your Provider Relations representative will work to take care of your concerns, suggestions or complaints in a timely manner. Most issues can be worked out by calling the Provider Relations department at 1-877-440-3738 between 8 a.m. and 7 p.m.

Abuse, Neglect and Exploitation
Report elder abuse, neglect and exploitation to the statewide Elder Abuse Hotline at 1-800-962-2873 (1-800-962-2873).

Abuse means any willful act or threatened act by a caregiver that causes or is likely to cause significant impairment to an enrollee’s physical, mental, or emotional health. Abuse includes acts and omissions.
Exploitation of a vulnerable adult means a person who:
1. Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use a vulnerable adult’s funds, assets or property for the benefit of someone other than the vulnerable adult.
2. Knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, the vulnerable adult’s funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit or possession of the funds, assets or property for the benefit of someone other than the vulnerable adult.

Neglect of an adult means the failure or omission on the part of the caregiver to provide the care, supervision and services necessary to maintain the physical and behavioral health of the vulnerable adult, including but not limited to food, clothing, medicine, shelter, supervision and medical services that a prudent person would consider essential for the well-being of the vulnerable adult. The term neglect also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect or exploitation by others. Neglect is repeated conduct or a single incident of carelessness that produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death.

The Health Insurance Portability and Accountability Act
The Health Insurance Portability and Accountability Act (HIPAA), also known as the Kennedy-Kassebaum bill, was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud and simplifies the administration of health insurance.

We strive to ensure both Amerigroup and contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to HIPAA. Effective April 14, 2003, contracted providers must have the appropriate procedures implemented to demonstrate compliance with HIPAA privacy regulations.

We recognize our responsibility under the HIPAA privacy regulations only to request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, you should only request the minimum necessary member information required to accomplish the intended purpose when contacting us. However, the privacy regulations allow the transfer or sharing of member information, such as a member’s medical record, which we may request to conduct business and make decisions about care in order to make an authorization determination or resolve a payment appeal. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at Amerigroup and verify the fax was received appropriately.
Email (unless encrypted) should not be used to transfer files containing member information to Amerigroup, e.g., Microsoft Excel spreadsheets with claim information. Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed, nylon-reinforced envelope marked confidential and addressed to a specific individual, post office box or department at Amerigroup.

Our voice mail system is secure and password-protected. When leaving messages for Amerigroup associates, only leave the minimum amount of member information required to accomplish the intended purpose.

When contacting us, please be prepared to verify your name and address and either your tax identification number, national provider identifier or Amerigroup provider number.

**Member Records**
Providers are required to maintain medical records for each patient in accordance with the medical record requirements below and with 42 CFR 431 and 42 CFR 456. A permanent medical record will be maintained at the primary care site for every member and be available to the PCP and other physicians. Medical records shall include the quality, quantity, appropriateness and timeliness of services performed.

Providers are required to have a designated person in charge of medical records. This person’s responsibilities include but are not limited to:
- The confidentiality, security and physical safety of records.
- The timely retrieval of individual records upon request.
- The unique identification of each patient’s record.
- The supervision of the collection, processing, maintenance, storage and appropriate access to the usage of records.
- The maintenance of a predetermined, organized and secured record format.

**Medical Record Standards**
Except when otherwise required by law, the content and format of clinical records, including the sequence of information, are uniform. Records are organized in a consistent manner that facilitates continuity of care.

All patient medical records are to reflect all aspects of patient care including ancillary services. Providers must follow the medical record standards set forth below for each member’s medical records as appropriate:
- Include the enrollee’s identifying information including name, enrollee identification number, date of birth, gender and legal guardianship or responsible party if applicable.
- Maintain each record legibly and in detail.
- Include a summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications and any other health conditions.
• Record the presence or absence of allergies and untoward reactions to drugs, current medications and/or materials in a prominent and consistent location in all clinical records. Note: This information should be verified at each patient encounter and updated whenever new allergies or sensitivities are identified.
• Ensure all entries are dated and signed by the appropriate party.
• Indicate in all entries the chief complaint or purpose of the visit, the objective, diagnoses, and medical findings or impression of the provider.
• Indicate in all entries the studies ordered (e.g., laboratory, X-ray, electrocardiogram) and referral reports.
• Indicate in all entries the therapies administered and prescribed.
• Record all medications prescribed and documentation or medication reconciliation, including any changes in prescription and nonprescription medication with name and dosage when available.
• Include in all entries the name and profession of the provider rendering services (e.g., M.D., D.O.), including the provider’s signature or initials.
• Include in all entries the disposition, recommendations, instructions to member, evidence of follow-up and outcome of services.
• Include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for children under 13 years of age.
• Ensure all records contain an immunization history and documentation of body mass index.
• Ensure all records contain information relating to the member’s use of tobacco products and alcohol and/or substance abuse.
• Ensure all records contain summaries of all emergency services and care and hospital discharges with appropriate and medically indicated follow-up.
• Document referral services in all members’ medical records.
• Include all services provided such as family planning services, preventive services and services for the treatment of sexually transmitted diseases.
• Ensure all records reflect the primary language spoken by the member and any translation needs of the member.
• Ensure all records identify members needing communication assistance in the delivery of health care services.
• Ensure all records contain documentation of the member being provided with written information concerning his or her rights regarding advance directives (i.e., written instructions for living will or power of attorney) and whether or not he or she has executed an advance directive. Note: Neither Amerigroup nor any of our contracted providers will require the member to execute or waive an advance directive as a condition of treatment. We will maintain written policies and procedures for advance directives.
• Maintain copies of any advance directives executed by the member.
• Enter significant medical advice given to a patient by telephone or online, including medical advice provided after-hours, in the patient’s clinical record and appropriately sign or initial.
• Clearly contrast any notation in a patient’s clinical record indicating diagnostic or therapeutic intervention as part of clinical research, with entries regarding the provision of nonresearch-related care.
• Review and incorporate all reports, histories, physicals, progress notes and other patient information such as laboratory reports, X-ray readings, operative reports and consultations into the record in a timely manner.
• Document a summary of past and current diagnoses or problems, including past procedures if a patient has had multiple visits/admissions, or the clinical record is complex and lengthy.
• Include a notation concerning cigarettes if present for patients 12 years of age and older. Abbreviations and symbols may be appropriate.
• Provide health education to the member.
• Screen patients for substance abuse and document as part of a prevention evaluation during the following times:
  o Initial contact with a new member
  o Routine physical examinations
  o Initial prenatal contact
  o When the member evidences serious overutilization of medical, surgical, trauma or emergency services
  o When documentation of emergency room visits suggests the need

The following requirements for patients’ medical records must also be met:
• **Consultations, referrals and specialist reports:** Notes from any referrals and consultations must be in the record. Consultation, lab and X-ray reports filed in the chart must have the ordering physician’s initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans including timely notification for the patient or responsible adult party.
• **Emergencies:** All emergency care provided directly by the contracted provider or through an emergency room, and the hospital discharge summaries for all hospital admissions while the patient is part of the PCP’s panel, must be noted.
• **Hospital discharge summaries:** Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the patient is enrolled and for admissions that occurred prior to the patient being enrolled as appropriate (i.e., pertinent to the patient’s medical condition).
• **Security:** Providers must maintain a written policy and are required to ensure medical records are safeguarded against loss, tampering, alteration, destruction, or unauthorized or inadvertent use.
• **Storage:** Providers must maintain a system for the proper collection, processing, maintenance, storage, retrieval and distribution of patient’s records. Also, the records must be easily accessible to personnel in the provider’s office and readily available to authorized personnel any time the organization is open to patients.
• **Release of information:** Written procedures are required for releasing information and obtaining consent for treatment.
• **Documentation:** Documentation is required setting forth the results of medical, preventive and behavioral health screenings as well as all treatment provided and the outcome of such treatment, including significant medical advice given to a patient by telephone.
• **Multidisciplinary teams:** Documentation is required of the team members involved in the multidisciplinary team of a patient needing specialty care.
• **Integration of clinical care:** Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include:
  o Screening for behavioral health conditions, including those which may be affecting physical health care and vice versa, and referral to behavioral health providers when problems are indicated.
  o Screening and referral by behavioral health providers to PCPs when appropriate.
  o Receipt of behavioral health referrals from physical medicine providers and the disposition/outcome of those referrals.
  o At least quarterly, or more often if clinically indicated, a summary of the status/progress from the behavioral health provider to the PCP.
  o A written release of information that will permit specific information-sharing between providers.
  o Documentation that behavioral health professionals are included in primary and specialty care service teams when a patient with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.
• **Domestic violence:** Documentation of screening and referral to applicable domestic violence prevention community agencies is required.
• **Consent for psychotherapeutic medications:** Pursuant to statute F.S. 409.912(51), providers must document informed consent from the parent or legal guardian of members younger than 13 who are prescribed psychotherapeutic medications. Providers must also provide the pharmacy with a signed attestation of this documentation, as pharmacies are required to obtain and keep these consents on file prior to filing a psychotherapeutic medication.
• **Behavioral health services provided through telemedicine:** Documentation of behavioral health services provided through telemedicine is required. Such documentation must include all of the following:
  o A brief explanation of the use of telemedicine in each progress note
  o Documentation of telemedicine equipment used for the particular covered services provided
  o A signed statement from the enrollee or the enrollee’s representative indicating the choice to receive services through telemedicine. This statement may be for a set period of treatment or for a one-time visit, as applicable to the service(s) provided
  o For telepsychiatry, the results of the assessment, findings and practitioner(s) plan for next steps.

Amerigroup will periodically review medical records to ensure compliance with these standards. We will institute actions, including corrective actions for improvement, when standards are not met.
5 COVERED HEALTH SERVICES

Summary of Benefits for Amerigroup Long-term Care Members
We provide the covered services listed below, and we must authorize covered services. Any modification to covered services will be communicated through a provider newsletter, provider manual and/or contractual amendment. The scope of benefits includes the following:

Home and Community Services
- Adult companion care
- Adult day health care
- Assisted living
- Assistive care services
- Attendant care
- Behavioral management
- Care coordination/case management
- Caregiver training
- Home accessibility adaptation
- Home-delivered meals
- Homemaker
- Hospice
- Intermittent and skilled nursing
- Medical equipment and supplies
- Medication administration
- Medication management
- Nursing facility
- Nutritional assessment/risk reduction
- Personal care
- Personal emergency response system (PERS)
- Respite care
- Occupational, physical, respiratory and speech therapies
- Transportation (nonemergency)

Managed Medical Assistance Services
- Advanced registered nurse practitioner
- Ambulatory surgical center services
- Assistive care services
- Behavioral health services
- Birth center and licensed midwife services
- Clinic services
- Chiropractic services
- Dental services
- Child health check up
- Immunizations
- Emergency services
- Emergency behavioral health services
- Family planning services and supplies
- Healthy start services
- Hearing services
- Home health services and nursing care
- Hospice services
- Hospital services
- Laboratory and imaging services
- Medical supplies, equipment, prostheses and orthoses
- Nursing facility services
- Optometric and vision services
- Physician assistant services
- Physician services
- Podiatric services
- Prescribed drug services
- Renal dialysis services
- Therapy service
- Transportation services

Expanded Benefits and Services
We cover additional benefits to eligible members besides what the Florida Statewide Medicaid Managed Care Long-term Care (SMMC-LTC) program offers. These expanded benefits include the following:
• Up to $2,500 towards transition costs for members relocating between service settings
• Adult preventive dental services
• Free SafeLink phone service minutes
• Up to $15 per month in over-the-counter (OTC) products
• Extra eyeglasses and contact lenses
• Access to a 24-hour Nurse HelpLine

Medical Services
Claims for covered SMMC-LTC services are covered by Amerigroup to the extent they are not covered by Medicare or other insurance or are reimbursed by Medicaid pursuant to Medicaid’s Medicare cost-sharing policies. These include:
• Durable medical equipment and supplies
• Home health nurse care
• Hospice services
• Inpatient hospital services
• Occupational, physical and speech therapy services
• Outpatient hospital/emergency medical services
• OTC drugs
• Vision services (if medical, Medicare is the primary payer)

We are responsible for Medicare coinsurance and deductibles as the secondary payer according to Medicaid guidelines. Services not covered by Medicare but offered through the SMMC-LTC program must be authorized by Amerigroup.

Emergency Services
We provide a Nurse HelpLine service 24 hours a day, 7 days a week, with clinical staff to provide triage advice and referral and, if necessary, to make arrangements for treatment of the member. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

We do not discourage members from using the 911 emergency system or deny access to emergency services. Emergency services are provided to members without requiring precertification. Any hospital or provider calling for an authorization for emergency services will be granted one immediately upon request. Emergency services coverage includes services needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part.
We coordinate emergency response with community services, including the police, fire and EMS departments, juvenile probation, the judicial system, child protective services, chemical dependency, and local mental health authorities if applicable.

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of, or in collaboration with, a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the member’s chart the results of the emergency medical screening examination. We will compensate the provider for the screening, evaluations and examination that are reasonable and calculated to assist the health care provider in determining whether or not the patient’s condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (i.e., whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on Amerigroup. If the emergency department is unable to stabilize and release the member, Amerigroup will assist in coordination of the inpatient admission, regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

If the member is admitted, the Amerigroup concurrent review nurse will implement the concurrent review process to ensure coordination of care.

**Member ID Card**

Each member is provided an ID card, which identifies the member as a participant in the Amerigroup program. The ID card includes:

- The member’s ID number
- The member’s first and last name and middle initial
- The member’s enrollment effective date
- A toll-free phone number for information and/or authorizations
- Descriptions of procedures to be followed for emergency or special services
Please note that possession of a card does not constitute eligibility for coverage. If an Amerigroup member is unable to present his or her membership card, please call the member’s case manager at 1-877-440-3738.
MEMBER ELIGIBILITY

Membership eligibility is determined by the Florida Agency for Health Care Administration (AHCA). Members eligible for Florida Statewide Medicaid Managed Care Long-term Care (SMMC-LTC) enrollment must be:

- 18 years or older
- Determined by the Florida Comprehensive Assessment and Review for Long-term Care Services (CARES) program to meet nursing facility level of care and be in any of the following programs or eligibility programs: Medicaid-eligible with an income up to the Institutional Care Program (ICP) level as defined by the Florida Department of Children and Families (DCF) (formerly the Department of Health and Rehabilitative Services) or are Medicaid-pending (i.e., waiting to find out if financial criteria for Medicaid are met)
- Residing in the SMMC-LTC program service area (Broward County)

Eligibility Determination
The Florida DCF and/or the federal Social Security Administration determine a person’s financial and categorical Medicaid eligibility. Financial eligibility for the SMMC-LTC program is based on Medicaid ICP income and asset level.

The Florida CARES program determines a person’s clinical eligibility for the SMMC-LTC program.

Ineligibility Determination
A person is not eligible for enrollment in the SMMC-LTC program if he or she resides outside the SMMC-LTC program service area.
7 MEMBER MANAGEMENT SUPPORT

Identifying and Verifying Long-term Care Members
Upon enrollment, we will send a welcome package to the member. This package includes an introductory letter, a member ID card, a provider directory and a member handbook. Each Amerigroup member will be identified by presenting an Amerigroup ID card, which includes a member ID number. You can check member eligibility online at https://providers.amerigroup.com/FL or by calling us at 1-877-440-3738.

Communication Access
For member communication access, we:
- Ensure members with low English proficiency have meaningful access to services.
- Make available (upon request) written member materials in large print, on tape and in languages other than English.
- Provide member materials written at the appropriate reading and/or grade level.
- Provide the assistance of an interpreter to communicate with a non-English-speaking member.
- Call Member Services at 1-800-600-4441 (TTY 1-800-855-2880) to access translation services for more than 200 languages.

Patient’s Bill of Rights
By Florida law, a health care provider or health care facility is required to recognize member rights while the member is receiving medical care. Additionally, the member is required to respect the health care provider’s or health care facility’s right to expect certain behavior. All providers are required to post this summary in their offices. Members may request a copy of the full text of this law from the health care provider or health care facility.
A member has the right to:
- Be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his or her care.
- Know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given by his or her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- Receive upon request a reasonable estimate of charges for medical care prior to treatment.
- Receive a copy of a reasonably clear and understandable itemized bill and, upon request, have the charges explained.
- Receive impartial access to medical treatment or accommodations regardless of race, national origin, religion, physical handicap or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
Know whether medical treatment is for purposes of experimental research and give his or her consent or refusal to participate in such experimental research.

Be assured confidential handling of medical records and, except when required by law, approve or refuse their release.

Express grievances regarding any violation of his or her rights as stated in Florida law through the grievance procedure of the health care provider or health care facility that served him or her and to the appropriate state licensing agency.

A member has the responsibility to:

- Provide to his or her health care provider accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters related to his or her health to the best of his or her knowledge.
- Report unexpected changes in his or her condition to the health care provider.
- Report to the health care provider whether he or she understands a suggested course of action and what is expected of him or her.
- Follow the treatment plan recommended by his or her health care provider.
- Keep appointments and, when unable to do so for any reason, notify the health care provider or health care facility.
- Be responsible for his or her actions if refusing treatment or not following the health care provider’s instructions.
- Ensure the financial obligations of his or her health care are fulfilled as promptly as possible.
- Follow health care facility rules and regulations affecting patient care and conduct.
- Members residing in nursing facilities, assisted living facilities or adult family care homes have patient financial responsibility in accordance to and as determined by the Department of Children and Families.

Cultural Competency

Cultural competency refers to the ability of individuals and systems to provide services effectively to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of individuals, and protects and preserves the dignity of each. We promote cultural competency. We collect information regarding the cultural differences of our members and provide training opportunities to staff and network providers, helping them learn how to interact effectively with members. Staff and provider cultural competency is monitored as part of our quality improvement process.

Poverty creates living situations (e.g., lack of a telephone, frequent residential moves and homelessness) and attributes (e.g., low or no literacy, non-English-speaking language skills) that can lead to difficulty interacting with members. Many Amerigroup members come from diverse cultural backgrounds with traditions, languages, and ways of perceiving others and the world around them differently. By understanding and being sensitive to these cultural differences, staff can avoid making inadvertent mistakes that may offend members and discourage them from accessing services or following treatment plans. Positive interactions with members should include communicating concern and empathy and helping members feel empowered regarding their own health care. This may encourage them to use services more appropriately.
If you would like a copy of the Amerigroup Cultural Competency program, you may request it from your Provider Relations representative at no cost to you. For additional training and tools related to cultural competency, go to minorityhealth.hhs.gov.

**Marketing**

Providers are permitted to make available and/or distribute Amerigroup marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all managed care plans with which the provider participates. Providers are also permitted to display posters or other materials in common areas such as the provider’s waiting room. Additionally, long-term care facilities are permitted to provide materials in admission packets announcing all managed care plan contractual relationships.

We will provide education and outreach and monitor activities to ensure you are aware of and comply with the following guidelines:

- To the extent a provider can assist a recipient in an objective assessment of his or her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.

- Providers may not:
  - Offer marketing/appointment forms.
  - Make phone calls or direct, urge or attempt to persuade recipients to enroll in a managed care plan based on financial or any other interests of the provider.
  - Mail marketing materials on behalf of a managed care plan.
  - Offer anything of value to induce recipients/enrollees to select them as their provider.
  - Offer inducements to persuade recipients to enroll in a managed care plan.
  - Conduct health screening as a marketing activity.
  - Accept compensation directly or indirectly from a managed care plan for marketing activities.
  - Distribute marketing materials within an exam room setting.
  - Furnish lists of their Medicaid patients or the membership of any managed care plan to a managed care plan.

- Providers may:
  - Provide the names of the managed care plans with which they participate.
  - Make available and/or distribute managed care plan marketing materials.
  - Refer their patients to other sources of information such as the managed care plan, the enrollment broker or the local Medicaid area office.
  - Share information with patients from the agency’s website or the CMS website.
  - Announce new or continuing affiliations with the managed care plan through general advertising (e.g., radio, television, websites).
  - Make new affiliation announcements within the first 30 calendar days of the new provider agreement.
  - Make one announcement to patients of a new affiliation that names only the managed care plan when the announcement is conveyed through direct mail, email or phone.
  - Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all managed care plans with which the provider participates.
• Any affiliation communication materials that include managed care plan-specific information (e.g., benefits, formularies) must be prior-approved by the agency.
  o Distribute printed information provided by the managed care plan to their patients comparing the benefits of all of the different managed care plans with which the providers contract.
8 CASE MANAGEMENT

Role of Case Managers
Amerigroup case managers are responsible for long-term care planning and for developing and carrying out strategies to coordinate and integrate the delivery of medical and long-term care services. Our Case Management department is dedicated to helping members obtain needed services. Each member is assigned to a case manager. Case managers will:
- Collaborate with physicians and other providers.
- Help members obtain needed services.
- Develop individual care plans.
- Coordinate and integrate acute and long-term care services.
- Visit members in their residences to evaluate and discuss needs.
- Issue authorizations to providers for covered services.
- Promote improvement in the member’s quality of life.
- Allocate appropriate health plan resources to the care and treatment of members with chronic diseases.

Case Management Interventions
Case management interventions can be performed by:
- Face-to-face home visits with the member and/or family.
- Telephonic follow-up with the member and/or family by a case manager.
- Providing educational materials.
- Communication with service providers.
- Coordination and integration of acute and long-term care services.

Referrals
The case manager is responsible for determining whether a referral for a long-term care covered service or a change in a long-term care service is appropriate. Authorization of new and/or changed services will be initiated when one of the following conditions applies:
- Services are necessary to address the member’s health and/or social service needs
- The member fails to respond to a current care plan
- Services are furnished in a manner not primarily intended for the convenience of the member, the member’s caregiver or the provider

For Statewide Medicaid Managed Care Long-term Care (SMMC-LTC) program members with Medicare: All referrals for services not covered by Medicare require authorization by the member’s case manager. Members requiring a Medicare-covered service must access the benefit through the Medicare fee-for-service program or through their Medicare health maintenance organization. We must authorize SMMC-LTC services. Contact the member’s case manager for authorization.

The member’s case manager may send you the following documents to help you provide covered services:
- **New Service Form** — used to initiate new services; usually used for home health, emergency response or meal providers
• **Hold/Resume Form** — used to place services on hold and resume services; usually used for home health, emergency response or meal providers

• **Change of Service Form** — used to change the frequency and duration of a service

• **Termination Form** — notifies providers to end services; usually used for home health, emergency response or meal providers

• **Authorization Form** — authorizes provider payment for covered services

**Hospital Admissions**
When you learn a member requires hospital admission or has been admitted to a hospital, an assisted living facility, home health care or nursing home, or is under the care of another provider, you should notify the member’s case manager. You must notify the Amerigroup case manager in writing within 24 hours if a member is hospitalized, discharged, moves out or is deceased. We will waive the bed-hold days for assisted living facility and nursing home providers if not provided with proper notification of a member’s relocation for inpatient stay, hospice admission, or temporary or permanent move. The Amerigroup case manager will proactively help the member with discharge planning needs prior to returning to the community by collaborating with the family, inpatient discharge planner and facility. Medicare, MMA or commercial coverage is the primary payer for inpatient hospital services. For questions regarding services, please contact the case manager at 1-877-440-3738.

**Interactive Voice Response**
The following providers are required to have 24-hour service:

- Assisted living facilities
- Adult family care homes
- Hospice centers
- Emergency response systems
- Nursing homes

Physicians will provide advice and assess care as appropriate for each member’s medical condition. Emergent conditions will be referred to the nearest emergency room.

**Disease Management Centralized Care Unit**
The Disease Management Centralized Care Unit (DMCCU) programs are based on a system of coordinated care management interventions and communications designed to assist physicians and others in managing members with chronic conditions. The program includes a holistic, member-centric care management approach that allows case managers to focus on multiple needs for members. Disease management includes programs for Alzheimer’s and dementia.

Program features:

- Uses proactive population identification processes
- Based on evidenced-based national practice guidelines
- Based on collaborative practice models to include physician and support-service providers in treatment planning for members
- Offers continuous patient self-management education, including primary prevention, behavior modification programs and compliance/surveillance, as well as home visits and case/care management for high-risk members
- Offers ongoing process and outcomes measurement, evaluation and management
- Offers ongoing communication with providers regarding patient status
Our disease management program is based on nationally approved clinical practice guidelines located at https://providers.amerigroup.com/FL. Simply access the Florida page and log in to the secure site by entering your login name and password. On the Online Inquiries page, scroll down to Resources, select Clinical Practice Guidelines link and select Florida. A copy of the guidelines can be printed from the website, or you can contact Provider Services at 1-800-454-3730 to receive a printed copy.

Who Is Eligible?
All members are eligible for the DMCCU services for which their conditions correspond. Members are identified through continuous case finding efforts that include but are not limited to welcome calls, claims mining and referrals.

DMCCU Provider Rights and Responsibilities
The provider has the right to:

- Have information about Amerigroup, including provided programs and services, our staff, and our staff’s qualifications and contractual relationships
- Decline to participate in or work with the Amerigroup programs and services for his or her patients, depending on contractual requirements
- Be informed of how Amerigroup coordinated interventions with treatment plans for individual patients
- Know how to contact the person responsible for managing and communicating with the provider’s patients
- Be supported by the organization to make decisions interactively with patients regarding their health care
- Receive courteous and respectful treatment from Amerigroup staff

Hours of Operation
Our disease management care managers are licensed nurses/social workers and are available from 8:30 a.m. to 5:30 p.m. local time, Monday through Friday. Confidential voice mail is available 24 hours a day.

Contact Information
Please call 1-888-830-4300 to reach a disease management care manager. Additional information about disease management can be obtained by visiting https://providers.amerigroup.com/FL. Select Florida, scroll down to Patient Support and select Disease Management Centralized Care Unit.

Members can obtain information about our DMCCU by visiting www.myamerigroup.com/FL or calling 1-888-830-4300.

Health Education Advisory Committee
The Health Education Advisory Committee provides advice to Amerigroup regarding health education and outreach program development. The Committee strives to ensure that materials and programs meet cultural competency requirements, are both understandable to the member and address the member’s health education needs.
The Health Education Advisory Committee’s responsibilities are to:

- Identify health education needs of the membership based on review of demographic and epidemiologic data.
- Assist the health plan in decision making in the areas of member grievances, marketing, member services, case management, outreach, health needs and cultural competency.
- Identify cultural values and beliefs that must be considered in developing a culturally competent health education program.
- Assist in review, development, implementation and evaluation of the member health education tools for the outreach program.
- Review the health education plan and make recommendations on health education strategies.
9 QUALITY MANAGEMENT

Our Quality Management program promotes quality member care and plan effectiveness through the assessment and improvement of care and practice patterns, improvement in health care outcomes, orientation and education of providers and members, and risk reduction. Our medical director and the associate vice president of Quality Management are responsible for our Quality Management program.

Quality Management Program
The Statewide Medicaid Managed Care Long-term Care (SMMC-LTC) program addresses the needs of all long-term care members and promotes improvement of quality-of-life. As part of the Amerigroup Quality Management program, we identify potential problematic areas for members and implement strategies for improvement. Our case management team helps ensure quality-of-life enhancements for members by monitoring quality, appropriateness and effectiveness of members’ care.

Our long-term care program relies on members, as well as their caregivers and providers, to help improve their quality of life. Provider communications about a member’s daily living needs offer the best information to case managers and help with quality management activities.

For members living at home, in an assisted living facility or in a nursing home, case managers promote members’ quality of life by developing members’ spirit, facilitating their freedom of choice by encouraging their individuality, promoting their independence, personalizing their services and helping them maintain their dignity.

Long-term Care Ethics and Quality Committee
The Long-term Care Ethics and Quality Committee addresses quality-of-care issues, ethical issues and standards of care. The committee reports to the Quality Management Committee.

The Amerigroup Quality Management program is a positive one. Our focus is on identification, improvement, education and support so providers understand and comply with standards that impact the quality of care provided to our members.

Provider Orientation, Monitoring and Education
Provider Relations conducts initial and ongoing in-services to providers. The in-service includes an overview of long-term care and member eligibility, the case manager’s role, authorization, and billing and contract information. Educational sessions can be scheduled at your convenience.

Amerigroup conducts monitoring visits in accordance with the Amerigroup credentialing and recredentialing policy. We will provide a thorough explanation of the monitoring and review findings during an exit conference on the day of the review. If your schedule does not allow for sufficient time on the day of the review, a follow-up appointment can be scheduled.

Provider Data Sharing
Provider data sharing reports are developed for providers and are used by Amerigroup in evaluating provider performance during credentialing and recredentialing procedures and recontracting decisions. Provider data sharing reports contain trended information from documentation reviews, member input, quality-of-care issues, contract compliance and comparisons with other providers in the same specialty.
Credentialing

Credentialing is an industry-standard, systemic approach to collecting and verifying an applicant’s professional qualifications. This approach includes a review of relevant training, licensure, certification and/or registration to practice in a health care field, and academic background.

Our credentialing process evaluates the information gathered and verified and determines whether the applicant meets certain criteria related to professional competence and conduct as well as licensure and certification. We use current National Committee for Quality Assurance (NCQA) and Accreditation Association for Ambulatory Health Care standards and guidelines for the accreditation of managed care organizations, as well as state-specific requirements, to credential and recredential licensed independent providers and organizational providers with whom we contract. This process is completed before a provider is accepted for participation in our network.

Credentialing Requirements

To become a participating Amerigroup provider, you must be eligible to enroll in the Medicaid program and must hold a current, unrestricted license issued by the state. We are authorized to take whatever steps necessary to ensure each provider is recognized by the state Medicaid program, including its choice of counseling/enrollment broker contractor(s) as a participating provider of Amerigroup, and the provider’s submission of encounter data is accepted by the Florida Medicaid Management Information Systems and/or the state’s encounter data warehouse. You must also comply with our credentialing criteria and submit all additionally requested information, including ownership and control information. To initiate the credentialing process, you must submit a complete Credentialing Application (individuals) or a Florida Long-term Care Application and all required attachments.

Credentialing Procedures

Our credentialing program includes, but is not limited to, the following types of providers:

- Doctors of dental surgery and medicine
- Physical, occupational, respiratory and speech language therapists
- Home-delivered meals and nutritional assessment/risk-reduction services
- Hospitals and allied services (ancillary) providers
- Long-term care providers, including:
  - Nursing home adult day health services, home health, nurse registry and assisted living services
  - Consumable medical supply services, escort services, chore services, environmental accessibility adaptation services and personal emergency response services (PERS)

We use a Credentialing Committee composed of licensed practitioners to review credentialing and recredentialing applicants, delegated groups, and sanctioned activity. The Credentialing Committee is also responsible for the creation and regular review of all policies and procedures relevant to the credentialing program.

We revise our credentialing policy periodically and no less often than annually based on input from:

- Credentialing committees
- Our health plan medical director
- Our chief medical officer
- State and federal requirements
By signing the application, you must attest to the accuracy of the credentials you provided on behalf of your individual or organizational provider application. If there are discrepancies between your application and the information obtained during our external verification process, our Credentialing department will investigate them. Discrepancies may be grounds for our denial of network participation or the termination of an existing contractual relationship. You will be notified by telephone or in writing if any information obtained during the process varies substantially from what was submitted.

Recredentialing
We require recredentialing every three years. We will perform recredentialing at least every 36 months, if not earlier. You will receive a request for your recredentialing application and supporting documentation in advance of the 36-month anniversary of your original credentialing or last credentialing cycle. We will assess information from quality improvement activities and member complaints, along with the assessments and verifications listed above.

Your Rights in the Credentialing and Recredentialing Process
You can request a status of your application by telephone, fax or mail.

You have the right to:
- Review information submitted to support your credentialing application
- Explain information obtained that may vary substantially from what you provided
- Provide corrections to any erroneous information submitted by another party; you can do this by submitting a written explanation or by appearing before the Credentialing Committee

Our medical director has the authority to approve clean files without input from the Credentialing Committee; all files not designated as clean will be sent to the Credentialing Committee for review and a decision regarding network participation.

We will inform you of the Credentialing Committee’s decision in writing within 60 days. If your participation is denied, you can appeal this decision in writing within 30 days of the date of the denial letter.

Long-term Care Providers
The following steps are included in our organizational provider credentialing process:
- Verification of a current copy of your state license; primary source verification is not required
- Investigation of any restrictions to a license, the results of which could impact your participation in our network
- Evidence of professional and general liability coverage; a copy of the face sheet will provide evidence of coverage. In addition, an attestation that includes the following information may be used:
  - Name of the carrier
  - Policy number
  - Coverage limits
  - Effective and expiration dates of such malpractice coverage
As a provider, you must maintain professional and general liability insurance in specified amounts in accordance with your Amerigroup contract.
• Disclosure of ownership statement: Centers for Medicare & Medicaid Services (CMS) requires us to obtain certain information regarding the ownership and control of entities with which we contract for services for federal employees or federal health plans. This form is required for participation in the Amerigroup network. All individuals and entities included on the form must be clear of any sanctions by Medicare or Medicaid

• A review and primary source verification of any Medicare or Medicaid sanctions

• A review and verification of accreditation by one of the following:
  o The Joint Commission (formerly JCAHO)
  o Accreditation Association for Ambulatory Health Care
  o American Association of Ambulatory Surgery Facilities
  o American Academy of Sleep Medicine
  o American Board for Certification in Orthotics, Prosthetics and Pedorthics
  o Commission on Accreditation of Rehabilitation Facilities
  o Community Health Accreditation Program
  o Continuing Care Accreditation Commission
  o College of American Pathologists
  o Accreditation Commission for Home Care
  o American College of Radiology
  o Council on Accreditation
  o Commission for the Accreditation of Birth Centers
  o Board Certification/Accreditation International
  o Commission on Accreditation for Home Care, Inc.
  o Healthcare Facilities Accreditation Program (formerly AOA Hospital Accreditation Program)
  o Intersocietal Accreditation Commission (CMS approved to handle MIPPA accreditation)
  o Det Norske Veritas (DNV) Healthcare, Inc. NIAHO Hospital Accreditation Program

If your provider is not accredited, a copy of a recent state or CMS review may be submitted in lieu of performing an onsite review. If there is no current accreditation or recent state or CMS review, we will perform an onsite review.

Your provider will:

• Be notified either by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted.

• Have the right to review the information submitted in support of the assessment process and to correct any errors in the documentation.

**Delegated Credentialing**
Provider groups with strong credentialing programs that meet Amerigroup credentialing standards may be evaluated for delegation. As part of this process, we will conduct a predelegation assessment of a group’s credentialing policy and program, as well as an onsite evaluation of credentialing files. A passing score is considered an overall average of 90-percent compliance. If deficiencies are identified, the group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results. If there are serious deficiencies, we will deny the delegation or will restrict the level of delegation.
We may waive the need for the predelegation onsite audit if the group’s credentialing program is National Committee for Quality Assurance-certified for all credentialing and recredentialing elements. We are responsible for ongoing oversight of any delegated credentialing arrangement and will schedule appropriate reviews. The reviews are held at least annually.
10 MEDICAL MANAGEMENT

Medical Review Criteria
As a wholly owned subsidiary of Anthem, we have adopted Anthem’s nationally recognized, evidence-based medical policies and clinical utilization management guidelines. These policies are publicly available on Anthem’s subsidiary websites — their purpose is to help you provide quality care by reducing inappropriate use of medical resources.

McKesson InterQual criteria will continue to be used when no specific Anthem medical policies exist. In all cases, Medicaid contracts or Centers for Medicare & Medicaid Services requirements supersede both McKesson InterQual and Anthem medical policy criteria.

- **Medically Necessary** services include medical, allied, or long-term care, goods or services furnished or ordered to meet the following conditions:
  - Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain
  - Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient’s needs
  - Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational
  - Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide
  - Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee’s caretaker or the provider

- For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

- The fact that a provider has prescribed, recommended or approved medical, allied, or long-term care goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

Precertification/Notification Process
Amerigroup may require members to seek a referral from their PCP prior to accessing nonemergency specialty physical health services.

Precertification is defined as the prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered and a member’s severity of illness, medical history and previous treatment, to determine the medical necessity and appropriateness of a given coverage request. **Prospective** means the coverage request occurred prior to the service being provided.

Notification is defined as a faxed, telephonic or electronic communication received from a provider informing Amerigroup of the intent to render covered medical services to a member. There is no review against medical necessity criteria; however, member eligibility and provider status (network and non-network) are verified. Notification should be provided prior to rendering services as
referenced in the Quick Reference Card. For services that are emergent or urgent, notification should be given within 24 hours or the next business day.

Authorizations that fall under the following categories will all be reviewed by a plan medical director for medical necessity:

A request for authorization of any medically necessary service for a member under 21 years of age when:

- The service is not listed in the service-specific Florida Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule, or;
- The service is not a covered service of the plan, or;
- The amount, frequency or duration of the service exceeds the limitations specified in the service-specific handbook, or;
- The corresponding fee schedule can be requested in the same manner as noted above.
11 MEMBER APPEAL AND GRIEVANCES PROCEDURES

Appealing on Behalf of a Member
If you are appealing on behalf of a member and do not have the Amerigroup Appeal Form completed and submitted to us to indicate you are the authorized representative appealing on behalf of the member, the appeal will be closed. Additionally, if you would like to complete a peer-to-peer review, we can arrange that. Please let us know you would like to talk to the physician reviewer.

The member has the right to examine the case file, including medical records and any other material to be considered during the process. He or she may ask for a free copy of the guidelines, records or other information used to make all decisions related to the appeal. The request can be made before, during or after the appeal.

What you should know:
• You can file an appeal on behalf of a member if you have the member’s consent.
• If coverage of the service you asked for has been denied, limited, reduced, suspended or terminated, you must ask for an appeal within 60 days of the date on the letter that said we would not pay for the service.
• You can ask for an expedited appeal if you think the member needs the services for an emergency or life-threatening illness.
• You can ask us to send you more information to help you understand why we would not pay for the service you requested.
• We only have one level of member appeal. During the appeal, a doctor who has not reviewed the case before will look at it and make a decision.

The Appeal Process
An appeal may be filed orally or in writing within 60 calendar days of receipt of our notice of adverse benefit determination. Except when expedited resolution is required, oral notice must be followed with a written notice within 10 calendar days of the oral filing. The date of oral notice will be considered the date of receipt.

There are two ways to submit an appeal:
1. Write us a letter and ask to appeal. You may also use the appeal form, which we can give you.
2. Call Member Services at 1-877-440-3738 and ask to appeal.

Member Rights in the Appeals Process
Please share this information with your Amerigroup patients to educate them on their rights in the appeals process:
• If you call us, we will send you an appeal form. If you want to have someone else help you with the appeal process, let us know, and we will send you a form for that as well. Fill out the whole form and mail it back to us. You must mail it back to us within 10 days of your call. In order to continue with the appeal, we must have the request in writing. We can also help you fill out the form when we talk to you on the phone.
• When we get your letter or appeal form, we will send you a letter within five business days to tell you we got your appeal.
• You may talk to the doctor who looks at your case; we can arrange for you to meet with or talk to this person.
• You may ask for a free copy of the guidelines, records or other information used to make this decision.
• We will tell you what the doctor decides within 30 calendar days of getting your appeal.
• If we reduce coverage for a service you are receiving right now and you want to continue to get the service during your appeal, you can call us to ask for it. You must call within 10 days of the date of the letter mailed to you that tells you we will not pay for the service.
• If you have more information to give us, you can bring it to us in person or write to us at the address below. Also, you can look at your medical records and information on this decision before and during the appeal process.
• The time frame for a grievance or appeal may be extended up to 14 calendar days if you ask for an extension or we find additional information is needed and the delay is in your interest. If the time frame is extended other than at your request, we will call you on the same day and notify you in writing within two calendar days of the determination of the reason for the delay.
• If you have a special need, we will give you additional help to file your appeal. Please call 1-877-440-3738 to ask for help. If you are deaf or hard of hearing, call the toll-free AT&T Relay Service at 1-800-855-2880.
• If you have any questions or need help, please call the Member Services department toll free at 1-877-440-3738. Member Services can assist you Monday through Friday from 8:00 a.m. to 7:00 p.m. Eastern time, excluding holidays.

Medical Appeals Address
Mail all of your medical information about the service with your letter to:

    Medical Appeals
    Amerigroup
    P.O. Box 62429
    Virginia Beach, VA 23466-2429

State Fair Hearing Process
A member may seek a Medicaid fair hearing any time up to 120 days after receiving Amerigroup’s notice of plan appeal resolution. The member must finish the appeal process first.

To have services continued, the member must request a fair hearing within 10 days from the date of the denial letter or within 10 business days after the intended effective date of the action, whichever is later. The member may have to pay for services received if a decision is made to uphold our decision. The Office of Fair Hearing is not part of Amerigroup; the Office looks at appeals of Medicaid members who live in Florida. We will give the office information about the case, including the information you have given us.
You or the member can contact the Medicaid Hearing Unit at:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

1-877-254-1055 (toll-free)
239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

Urgent or Expedited Appeals
- You or the member can ask for an urgent or expedited appeal if you think the time frame for a standard appeal process could seriously jeopardize the member’s life, health or ability to attain, maintain or regain maximum function.
- You or the member can also call Member Services toll free at 1-877-440-3738 to ask for an expedited appeal.
- We will resolve each expedited appeal and provide notice to you and the member as quickly as the member’s health condition requires within state-established time frames not to exceed 72 hours after we receive the appeal request. If we deny your request for expedited appeal, we will notify you that the appeal will be transferred to the time frame for standard resolution.

External Appeal Reviews
After getting a final decision from us, members can call or write the Subscriber Assistance Program (SAP) at:

Subscriber Assistance Program
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #45
Tallahassee, FL 32308
Toll free: 1-888-419-3456
Local number: 850-412-4502

Before filing with the SAP, the member must finish the Amerigroup appeals process.

The member must ask for the appeal to the SAP within one year after getting the final decision letter from us. The SAP will not handle an appeal that has already been to a Medicaid fair hearing.

The SAP will finish its review and make a decision.

Member Handbook: Appeal and Grievance Procedures
Members have the right to tell us if they’re not happy with their care or the coverage of their health-care needs. These are called grievances and appeals. Members can talk to someone from grievance and appeals Monday through Friday from 8:30 a.m.-5:30 p.m. Eastern time.

A grievance is when a member is not happy about something besides their benefits. A grievance could be about a provider’s behavior or about information a member should have received but didn’t.
An appeal is when members feel they should be getting a service covered and they’re not or that service has been stopped.

For your reference, below are the member grievance and appeals procedures as presented to our members in their Member Handbook:

Complaints and Grievances
I Have a Concern I Would Like to Report.
Amerigroup has a process to solve complaints and grievances. If you have a concern that is easy to solve and can be resolved within 24 hours, Member Services will help you. If your concern can’t be handled within 24 hours and needs to be looked at by our grievance coordinator, your call will be transferred to the grievance and appeals coordinator.

How do I let Amerigroup know about my concern?
A complaint or grievance must be given by phone, in person or in writing anytime after the event happened. To file a complaint or grievance with a grievance and appeals coordinator:
1. Call Member Services at 1-877-440-3738 (TTY 711).
2. Write us a letter regarding your concern. Mail it to:
   Grievance and Appeals Coordinator
   Amerigroup
   4200 W. Cypress St., Suite 900
   Tampa, FL 33607-4173

You can have someone else help you with the grievance process. This person can be any of the following:
- A family member
- A friend
- Your doctor
- A lawyer

Write this person’s name on the grievance form.

If you need help filing the complaint, Amerigroup can help. Call Member Services at 1-877-440-3738 (TTY 711) and a grievance and appeals coordinator will help you. Once Amerigroup gets your grievance (oral or written), we will send you a letter within five business days. This letter will tell you the date we got your grievance.

What happens if I have additional information?
If you have more information you want us to have:
1. Bring it to us in person or mail it to:
   Grievance and Appeals Coordinator
   Amerigroup
   4200 W. Cypress St., Suite 900
   Tampa, FL 33607-4173
2. Ask for the grievance and appeals coordinator to call you when you send in your grievance.
3. Call the grievance and appeals coordinator at 1-877-440-3738 (TTY 711).
What happens next?
The grievance coordinator will review your concern. If more information is needed or you have asked to talk to the coordinator, he or she will call you. Medical concerns are looked at by medical staff. Amerigroup will tell you the decision of your grievance within 30 calendar days from the date we got your grievance.

What happens if I want an extension?
Although Amerigroup normally will resolve your concern within 30 calendar days, there are times when an extension is needed. Amerigroup may extend the time it takes to resolve your concern up to 14 calendar days if:
1. You request an extension.
2. Amerigroup needs additional information and we believe by extending the time it is in your best interest.

Amerigroup will call you the same day and let you know in writing, within two calendar days of our identification, that a grievance extension is needed.

Medical Appeals
There may be times when Amerigroup says it will not pay, in whole or in part, for care that your doctor has asked for. If we do this, you (or your doctor for you and with your written approval) can appeal the decision. A medical appeal is when you ask Amerigroup to look again at the care your doctor asked for, and we said we will not pay for. You must file for an appeal within 60 calendar days from the date on the letter that says we will not pay for a service. Amerigroup will not act differently toward you or the doctor who helped file an appeal.

I want to ask for an appeal. How do I do it?
An appeal may be filed out loud by phone or in writing. This needs to be within 60 calendar days of when you get the notice of adverse benefit determination. There are two ways to file an appeal:
1. Write and ask to appeal. Mail the appeal request and all medical information to:
   Grievance and Appeals Coordinator
   Amerigroup
   4200 W. Cypress St., Suite 900
   Tampa, FL 33607-4173
2. Call the grievance and appeal coordinator toll-free at 1-877-440-3738 (TTY 711). Except when an expedited ruling is needed, an oral notice must be followed by a written notice within 10 calendar days of the oral notice. The date of the oral notice will be the date of receipt.

What else do I need to know?
When we get your letter, we will send you a letter within five business days. This will tell you we got your appeal. You may talk to the doctor who looks at your case. We’ll help you meet with or talk to him or her. You may also ask for a free copy of the guidelines, records or other information used to make this ruling. We’ll tell you what the ruling is within 30 calendar days of getting your appeal request.
What if I have more information I want you to have?
If you have more information to give us, bring it in person or mail it to the Medical Appeals address above. Also, you can look at your medical records and information on this ruling before and during the appeal process. The time frame for an appeal may be extended up to 14 calendar days if:
- You ask for an extension.
- Amerigroup finds additional information is needed, and the delay is in your interest.

If the time frame is prolonged other than at your request, Amerigroup will call you on the same day and let you know in writing within two calendar days of when the ruling is made.

If you have a special need, we will give you extra help to file your appeal. Please call Member Services at 1-800-600-4441 (TTY 711) Monday through Friday from 8 a.m.-7 p.m. Eastern time.

What can I do if I think I need an urgent or expedited appeal?
You or your doctor or someone on your behalf can ask for an urgent or expedited appeal if:
- You think the time frame for a standard appeal process could seriously harm your life or health or ability to attain, maintain or regain maximum function, based on a prudent layperson’s judgment.
- In the opinion of your doctor who has knowledge of your medical condition, a standard appeal would subject you to severe pain that cannot be well-managed without the care or treatment that is the subject of the request.

You can also ask for an expedited appeal by calling Member Services toll-free at 1-877-440-3738 (TTY 711) Monday through Friday from 8 a.m.-7 p.m. Eastern time. Should you require an expedited appeal during nonworking hours, Amerigroup On Call, our 24-hour nurse helpline, can handle your appeal request.

If you have any questions, need help or would like to talk to the grievance and appeals coordinator, call Member Services toll-free at 1-877-440-3738 (TTY 711) Monday through Friday from 8 a.m.-7 p.m. Eastern time.

We must respond to you by phone or in person within 72 hours after we receive the appeal request, whether the appeal was made out loud by phone or in writing. Amerigroup will follow up in writing no later than three calendar days after the initial oral notification. If the request for an expedited appeal is denied:
- The appeal will be transferred to the time frame for standard resolution.
- You will be notified within 72 hours.

What if my health care was reduced, postponed or ended, and I want to keep getting health care while my appeal is in review?
Call Member Services if you would like to keep your benefits during your appeal. Amerigroup will continue your benefits if:
1. You or your authorized representative file an appeal with Amerigroup regarding the decision either:
   a. Within 10 business days after the notice of the adverse action is mailed.
   b. Within 10 business days after the intended effective date of the action, whichever is later.
2. The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
3. The services were ordered by an authorized provider.
4. The original period covered by the original authorization has not expired.
5. You request extension of benefits.

If you meet these requirements, Amerigroup will approve the service until one of the following happens:
1. You withdraw the appeal.
2. Ten business days pass after Amerigroup sends you the notice of resolution of the appeal against you, unless within those 10 days you have requested a Medicaid fair hearing with continuation of benefits.
3. The Medicaid fair hearing office issues a hearing decision adverse to you.
4. The time period or service limits of a previously authorized service have been met.

If the state fair hearing or Subscriber Assistance Program agrees with us, you may have to pay for the care you got during the appeal.

**What can I do if Amerigroup still will not pay?**
You have a right to ask for a state fair hearing. You must request a grievance or an appeal before you ask for the fair hearing. If you ask for a fair hearing, you must do so no later than 120 calendar days of getting our letter that says we will not pay for a service.

The Medicaid Hearing Unit is not part of Amerigroup. This office looks at appeals from Florida Medicaid members. If you contact the Medicaid Hearing Unit, we will give them facts about your case. This includes the details you have given us.

**How do I contact the state for a fair hearing?**
You can contact the Medicaid Hearing Unit at any time during the Amerigroup appeals process. They are at:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906
1-877-254-1055 (toll-free)
239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

You have the right to ask to get benefits during your hearing. Call Member Services toll-free at 1-877-440-3738 (TTY 711). If the Medicaid Hearing Unit agrees with Amerigroup, you may have to pay for services you got during the appeal.
How do I ask for an external appeals review?
After getting a final ruling from Amerigroup, call or write the Subscriber Assistance Program (SAP) at:

Agency for Health Care Administration (AHCA)
Subscriber Assistance Program
Mail Stop #45
2727 Mahan Drive
Tallahassee, FL 32308
Toll-free phone number: 1-888-419-3456
Local number: 850-412-4502

Before filing with the SAP, you must finish the Amerigroup appeals process. You must ask for your SAP appeal within one year after you get the final ruling letter from Amerigroup. The SAP will not look at an appeal that has already been to a Medicaid fair hearing.

The SAP will complete its review and make a ruling. Rulings made through a state fair hearing or Subscriber Assistance Program review are final.

If you have any questions or need help filing an appeal with Amerigroup, call Member Services toll free at 1-877-440-3738 (TTY 711) Monday through Friday from 8 a.m.-7 p.m. Eastern time.

Member Dissatisfaction and Grievances
Members who wish to file a grievance through their provider should receive a grievance form from the provider. Once completed, the member or provider can forward the grievance form with any supporting documentation to the attention of our Grievance Unit.

Dissatisfaction Process
We will make every effort to resolve each member dissatisfaction before it becomes a grievance. We encourage members to voice even minor concerns early by contacting their case manager. The vast majority of concerns are resolved at the time of initial contact.

Whether received by telephone or in writing, all member concerns are immediately logged into the Amerigroup Management Information System. If the member’s concern cannot be resolved by the close of the next business day, the concern becomes a formal grievance. We will send a letter acknowledging receipt of the request.

A Member Services representative or case manager logs all dissatisfaction, both oral and written, and tries to resolve the complaint immediately. If the dissatisfaction cannot be resolved at the time of the call, it is forwarded to Quality Management for resolution as a grievance. Quality Management works with the appropriate department within Amerigroup for investigation and review. Member Services uses the language line for assistance, as needed, with interpretive services.

Complaint and grievance procedures are provided to members and providers in alternative formats as needed. This includes audio, large print, Braille and Spanish. TDD/TTY lines and sign language interpreters are also available. If a member needs help completing a grievance/appeal form, assistance
will be provided by telephone, or a member advocate representative will contact the member to provide the requested assistance and may fill out the form for the member. In addition, grievance/appeal forms are available at providers’ offices. These assistance services are available at all steps of the grievance and appeal process.

Other Dissatisfactions Handled by Amerigroup
Member dissatisfactions pertaining to receipt of vision and dental services are referred to the respective subcontractor, including Ocular Benefits and DentaQuest. The subcontractor for these services must report all member dissatisfactions, including the type of complaint and resolution status, to us on a monthly basis. We incorporate this information into the grievance/appeal database for monitoring and trending. If the member calls back and is not satisfied with the response from the subcontractor’s Member Services department, an Amerigroup Member Services representative will try to conduct a three-way conference call with the subcontractor and the member to resolve the issue immediately. Member Services may also refer the issue to our Quality Management department for further review or assistance.

If a vendor receives a complaint from a member related to nonemergent transportation, the vendor will warm transfer the member to Amerigroup for the complaint to be documented. In this situation, the vendor will not respond to the member.

Grievance Process
A grievance is an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include but are not limited to the quality of care, the quality of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the member’s rights.

Members may file a formal grievance either verbally or in writing at any time after the date of service or occurrence. We can help members write grievances as necessary. All grievances will be acknowledged within five business days. All grievances except clinically related issues are investigated by Grievance department staff with the cooperation of other departments directly involved with the member’s concerns. Members may file a grievance by contacting:

Grievance Coordinator
Amerigroup
4200 W. Cypress St., Suite 900
Tampa, FL 33607-4173
Office hours from 8 a.m.-7 p.m.
Telephone: 1-877-440-3738

Resolution of a member’s grievance must be completed within 30 days of receipt of the grievance. If the review process takes longer than 30 days, we will send a follow-up letter to the member explaining the status of his or her case. If an extension is needed, we will send a letter to the member explaining the status of the case and the need for an extension. We will also send the member a resolution letter discussing our decision and the member’s right to appeal.
If a grievance involves a quality-of-care concern, all providers, agents and employees of Amerigroup can complete a plan inquiry form and forward it to the Quality Management department for confidential review.

Medicaid members have the option to request a Medicaid fair hearing after the grievance process is completed by contacting:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906
1-877-254-1055 (toll-free)
239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

Provider Complaint System
Our provider complaint system allows you to dispute Amerigroup policies, procedures or any aspect of our administrative functions, including proposed actions. You have 45 calendar days from the date of the occurrence to file a written complaint regarding the dispute. Complaints will be resolved fairly – consistent with health plan policies and covered benefits.

Process for Filing and Submitting a Formal Complaint
You can file a written formal complaint with us via email, fax, mail or in-person. Any supporting documentation should accompany the grievance. For assistance with filing a complaint, call Provider Services at 1-800-454-3730.

We will:
- Allow 45 days for providers to file a written complaint.
- Notify the provider (verbally or in writing) within three business days of receipt that we have received the complaint and include an expected date of resolution.
- Document why a complaint is unresolved after 15 days of receipt and provide written notice of the status to the provider every 15 days thereafter.
- Resolve all complaints within 90 days of receipt and provide written notice of the disposition as well as the basis of the resolution within three business days of the resolution.

Amerigroup keeps all provider complaints confidential to the extent permitted under applicable law. We will not penalize a provider for filing a complaint.

Provider Complaint Review
Upon receipt of a complaint with supporting documentation, we will thoroughly investigate the complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying Amerigroup written policies and procedures. The account executive/manager or director is responsible for resolution of unresolved issues. We will communicate resolution of the issue in writing.
Claims Payment Inquiries or Appeals
Our Provider Experience program helps you with claims payment and issue resolution. Just call 1-800-454-3730 and select the Claims prompt.

We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:
- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

For members who reside in a residential facility, there are requirements for patient responsibility. Residential facilities are nursing homes, adult family care homes and assisted living facilities. Patient responsibility is calculated by the Department of Children and Families. In accordance with Title 42, Section 435.726, Code of Federal Regulations & Section 2404 of the Affordable Care Act, patient liability will be withheld from billed charges per the Medicaid Provider Reimbursement Handbook guidelines.

Claims Correspondence versus Payment Appeal
The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue. The following table also provides guidance on issues considered claim correspondence and should not go through the Payment Appeal process.

<table>
<thead>
<tr>
<th>Type of Issue</th>
<th>What Do I Need to Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rejected Claim(s)</td>
<td>Use the <strong>EDI Hotline</strong> at 1-800-590-5745 when your claim was submitted electronically but was never paid or was rejected. We’re available to assist you with setup questions and help resolve submission issues or electronic claims rejections.</td>
</tr>
<tr>
<td>Explanation of Payment Requests for Supporting Documentation (Sterilization/Hysterectomy/Abortion Consent Forms, itemized bills, and invoices)</td>
<td>Submit a Claim Correspondence form, a copy of your Explanation of Payment (EOP) and the supporting documentation to: Florida Claims Correspondence Amerigroup P.O. Box 61599 Virginia Beach, VA 23466-1599</td>
</tr>
<tr>
<td>Explanation of Payment Requests for Medical Records</td>
<td>Submit a Claim Correspondence form, a copy of your EOP and the medical records to: Florida Claims Correspondence Amerigroup P.O. Box 61599 Virginia Beach, VA 23466-1599</td>
</tr>
</tbody>
</table>
### Type of Issue | What Do I Need to Do?
--- | ---
**Need to Submit a Corrected Claim Due to Errors or Changes on Original Submission** | Submit a Claim Correspondence form and your corrected claim to: Florida Claims Correspondence Amerigroup P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return.

**Submission of coordination of benefits/third-party liability information** | Submit a Claim Correspondence form, a copy of your EOP and the COB/TPL information to: Florida Claims Correspondence Amerigroup P.O. Box 61599 Virginia Beach, VA 23466-1599

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A claim payment appeal (dispute) is any dispute between you and Amerigroup for reason(s) including:

- Contractual payment issues
- Inappropriate or unapproved referrals initiated by providers
- Retrospective review
- Disagreements over reduced or zero-paid claims
- Authorization issues
- Timely filing issues
- Other health insurance denial issues
- Claim code editing issues
- Duplicate claim issues
- Retro-eligibility issues
- Experimental/investigational procedure issues
- Claim data issues

You will **not** be penalized for filing a payment dispute. No action is required by the member. Our procedure is designed to give you access to a timely payment appeal process. We have a two-level appeal process for provider’s to dispute claim payment. If you are dissatisfied with the resolution of a first level appeal, we give you the option to file a second-level appeal.

For claims payment issues related to denial based on medical necessity, we contract with physicians who are not network providers to resolve claims appeals that remain unresolved subsequent to first level determination.

We will abide by the determination of the physician resolving the dispute. You will be expected to do the same. We will ensure the physician resolving the dispute will hold the same specialty or a related specialty as the appealing provider.

If you disagree with a previously processed claim or adjustment, you may submit a verbal or written request for reconsideration to us.

Due to the nature of appeals, some cannot be accepted verbally and therefore must be submitted in writing. The following table provides guidance for determining the appropriate submission method.
<table>
<thead>
<tr>
<th>Issue Type</th>
<th>Written or Verbal Request Allowed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denied for timely filing</td>
<td>• If we made an error per your contract: verbal allowed&lt;br&gt;• If you have paper proof: written</td>
</tr>
<tr>
<td>Denied for no authorization</td>
<td>• If you know an authorization was provided and we made an error: verbal allowed&lt;br&gt;• If you have paper proof: written</td>
</tr>
<tr>
<td>Retro-authorization issue</td>
<td>• If requesting retro-review: written</td>
</tr>
<tr>
<td>Denied for needing additional medical records (Denials issued for this reason are considered non-clean claims and will not be logged as appeals. These will be treated as inquiries/correspondence.)</td>
<td>• If records have not been received previous to call: written&lt;br&gt;• If records were sent previously and you know they were received and on file: verbal</td>
</tr>
<tr>
<td>You feel you were not paid according to your contract, such as at appropriate DRG or per diem rate, fee schedule, Service Case Agreement, or appropriate bed type, etc.</td>
<td>Verbal</td>
</tr>
<tr>
<td>The member doesn’t have OHI, but claim denied for OHI</td>
<td>Verbal</td>
</tr>
<tr>
<td>Claim code editing denial</td>
<td>Written</td>
</tr>
<tr>
<td>Denied as duplicate</td>
<td>Verbal</td>
</tr>
<tr>
<td>Claim denied related to provider data issue</td>
<td>Verbal</td>
</tr>
<tr>
<td>Retro-eligibility issue</td>
<td>Verbal</td>
</tr>
<tr>
<td>Experimental/investigational procedure denial</td>
<td>Written</td>
</tr>
<tr>
<td>Claims data entry error; data elements on the claim on file does not match the claim you submitted</td>
<td>Verbal</td>
</tr>
<tr>
<td>Second-level appeal</td>
<td>Written (verbal not accepted)</td>
</tr>
</tbody>
</table>

If after reviewing this table and determining a verbal appeal is allowed, you can call the PSU at 1-800-454-3730. If the appeal must be submitted in writing or if you wish to use the written process instead of the verbal process, the appeal should be submitted in to:

Amerigroup Payment Appeals  
P.O. Box 61599  
Virginia Beach, VA 23466-1599

Written appeals with supporting documentation can also be submitted via the Payment Appeal tool on our provider website. When inquiring on the status of a claim, if a claim is considered appealable due to no or partial payment, a dispute selection box will display. Once this box is clicked, a Web form will display for you to complete and submit. If all required fields are completed, you will receive immediate acknowledgement of your submission.

When using the online tool, supporting documentation can be uploaded using the attachment feature on the Web dispute form and will attach to the form when submitted.
The payment appeal for reconsideration, whether verbal or written, must be received by Amerigroup within 120 calendar days of the EOP paid date or recoupment date.

When submitting the appeal verbally or in writing you need to provide:

- A listing of disputed claims.
- A detailed explanation of the reason for the appeal.
- Supporting statements for verbal appeals and supporting documentation for written.

Written appeals should also include a copy of the EOP and an Appeal Request form.

Verbal appeals received by the PSU are logged into the appeal database. Written payment appeals are received in our Document Management Department (DMD) and are date-stamped upon receipt. The DMD scans the appeal into our document management system (Macess), which stamps the image with the received date and the scan date. Once the dispute has been scanned, it is logged into the appeal database by the Intake team within the DMD.

Once the appeal is logged, it is routed in the database to the appropriate appeal unit. The appeal associates work appeals by demand drawing items based first-in, first-out criteria for routing appeals. The appeal associate will:

- Review the appeal and determine the next steps needed for the payment appeal.
- Make a final determination if able based on the issue or will route to the appropriate functional area(s) for review and determination.
- Ensure a determination is made within 30 calendar days of the receipt of the payment appeal.
- Contact you via your preferred method of communication (phone, fax, email or letter) and provide the payment information, if overturned, or further appeal rights if upheld or partially upheld. Your preferred method of communication is determined from the PSU agent requesting this information during your call or your selection on the Appeal Request form. If no preference is provided, a letter will be mailed to you.

If your claim(s) remains denied, partially paid or you continue to disagree, you may file a second-level appeal in writing. Second-level verbal appeals will not be accepted. The second-level appeal must be received by us within 30 calendar days from the date of the first-level decision/resolution letter. Second-level appeals received after this will be upheld for untimely filing and will not be considered for further payment. You must submit a written second-level dispute to the centralized address for disputes. A more senior appeal associate, or one who did not complete the first-level review, will conduct the second-level review. If additional information is submitted to support payment, the denial is overturned. Otherwise, the appeal associate conducts the review as per the steps in the first-level process.

Once the dispute is reviewed for the second level, the appeal associate will notify you of the decision via your preferred method of communication within 30 calendar days of receipt of the second-level payment appeal.

A licensed/registered nurse will review payment appeals received with supporting clinical documentation when medical necessity review is required. We will apply established clinical criteria to
the payment appeal. After review, we will either approve the payment dispute or forward it to the medical director for further review and resolution.

If you are dissatisfied with the Level II payment dispute resolution, you may appeal our decision to Maximus, the AHCA vendor for provider disputes.

Application forms and instructions on how to file claims are available from Maximus. For information updates, call Maximus directly at 1-800-356-8151 and ask for the Florida Appeals Process department.
12 RISK MANAGEMENT

Risk management is defined as the identification, investigation, analysis and evaluation of risks and the selection of the most advantageous method of correcting, reducing or eliminating identifiable risks.

The Risk Management program at Amerigroup is intended to:

- Protect and conserve the human and financial assets, public image and reputation of the provider of care and/or the organization from the consequences of risks associated with members, visitors and employees at the lowest reasonable cost
- Minimize the incidents of legal claims against the provider of care and/or organization
- Enhance the quality of care provided to members
- Control the cost of losses
- Maintain patient satisfaction with the provider of care and the organization

The scope of our Risk Management program is organization-wide. Each member of the medical care team has an equally important role to play in minimizing the occurrence of incidents. All care providers, agents and employees of Amerigroup have the affirmative duty to report adverse or untoward incidents (potential or actual) on an incident report and to send the report to specific personnel for necessary follow-up.

The risk manager’s activities will contribute to the quality of care and a safer environment for members, employees, visitors and property, as well as reduce the cost of risk to the provider and the organization.

These activities are categorized as those directed toward loss prevention (preloss) and those for loss reduction (postloss).

The primary goal of preloss activity is to correct, reduce, modify or eliminate all identifiable risk situations, which could result in claims and litigation for injury or loss. This can be accomplished by:

- Providing ongoing education and training programs in risk management and risk prevention.
- Participating in safety, utilization review, quality assessment and improvement activities.
- Interfacing with the medical staff to ensure communication and cooperation in risk management.
- Exchanging information with professional organizations, peers and other resources to improve and update the program.
- Analyzing member grievances that relate to member care and the quality of medical services for trends and patterns.

The primary goal of postloss activity is the selection of the most advantageous methods of correcting identifiable risks and claim control. This can be accomplished through an effective and efficient incident reporting system.

All Amerigroup employees will be given education on the Internal Incident Reporting System, which outlines incident-reporting responsibilities and includes the definition of adverse or untoward incidents, a copy of the plan inquiry form, appropriate routing, and the required time frame for reporting incidents to the risk manager.
Your input and participation in the quality management process further emphasizes the identification of potential risks in the clinical aspects of member care.

**Internal Incident Reporting System**
The Internal Incident Reporting System establishes the policy and procedure for reporting adverse or untoward incidents that occur.

**Definitions**

**Adverse or untoward incident**: an event over which health care personnel could exercise control and:
- Is more probably associated in whole or in part with medical intervention rather than the condition for which such intervention occurred.
- Is not consistent with or expected to be a consequence of such medical interventions.
- Occurs as a result of medical intervention to which the member has not given his or her informed consent.
- Occurs as a result of any other action or lack thereof on the part of the facility or personnel of the facility.
- Results in a surgical procedure being performed on the wrong member.
- Results in a surgical procedure unrelated to the member’s diagnosis or medical needs being performed on any member.
- Causes injury to a member as defined below.

**Injury**: any of the following outcomes, when caused by an adverse incident:
- Death
- Fetal death
- Brain damage
- Spinal damage
- Surgical procedure performed on the wrong site
- Surgical procedure performed on the wrong patient
- Wrong surgical procedure
- Surgical procedure unrelated to the patient’s diagnosis
- Surgical procedure to remove foreign objects remaining from a surgical procedure

These issues are applicable to all Amerigroup members:
- Abuse/neglect
- Altercations
- Elopement
- Escape
- Exploitation
- Homicide
- Injury or illness
- Medication errors
- Sexual battery
- Suicide
- Suicide attempt

**Reporting Responsibilities**
All incidents involving members must be reported to the risk manager or risk manager designee within three calendar days. If the incident has resulted in serious or potentially serious member harm (Code 15), the risk manager must be contacted immediately if during the day, and the medical director must be contacted immediately if during the night. We must report a Code 15 incident to AHCA within three
calendar days of its occurrence. A more detailed follow-up report must be submitted to AHCA within 10 days after the first report. AHCA may require an additional final report.

All participating and direct service providers, **including HCBS providers**, are required to report adverse incidents to Amerigroup within 24 hours of the incident. Amerigroup must ensure all participating and direct service providers are required to report adverse incidents to the Agency immediately, but no more than 24 hours of the incident. Reporting will include information on the enrollee’s identity and a description of the incident and outcomes, including current status of the enrollee.

Amerigroup shall report suspected adult abuse, neglect and exploitation of enrollees immediately, in accordance with Chapter 415, F.S. Suspected cases of abuse, neglect and/or exploitation must be reported to the state’s Adult Protective Services unit. The Florida Adult Protective Services has the responsibility for investigating allegations of abuse, neglect and exploitation of elders and individuals with disabilities.

**Procedural Responsibilities**

- The provider staff member involved in observing or first discovering the unusual incident or an Amerigroup staff member who becomes aware of an incident is responsible for initiating the incident report before the end of the working day. Reports will be fully completed on the incident report form and will provide a clear, concise, objective description of the incident. The director of the department involved in observing the risk situation will assist in the completion of the form if necessary.
- The director of the department involved will forward all incident reports to the risk manager or risk manager designee within three calendar days. Upon being logged and date-stamped by the risk manager, the Quality Management (QM) department will solicit information from other departments and/or providers. All incident reports resulting in serious or potentially serious member harm will be forwarded to the risk manager or risk manager designee immediately for consideration of Code 15 reporting.
- The National Customer Care department associate is responsible for initiating incident reports for member grievances that relate to an adverse or untoward incident.
- The QM committee will review all pertinent safety-related reports.
- The QM committee, medical advisory committee and/or peer review committee will review pertinent member-related reports.
- Documentation related to the suspected abuse, neglect or exploitation, including the reporting of such, must be kept in a file, separate from the enrollee’s case file, that is designated as confidential. Such file shall be made available to the AHCA upon request.
- The only copy of a member incident report will be kept in the office of the risk manager; reports will not be photocopies or carbon copies. Employees, providers and agents are prohibited from placing copies of an incident report in the medical record. Employees, providers and agents are prohibited from making a notation in the medical record referencing the filing of an incident report.

**Incident Report Review and Analysis**

- The risk manager will review all incident reports and analyze them for trends and patterns. This includes the frequency, cause and severity of incidents by location, provider and type of incident.
- The risk manager will have free access to all health maintenance organization or provider medical records.
- The incident reports will be utilized to develop categories of incidents that identify problems.
- Once problems become evident, the risk manager will make recommendations for corrective actions such as procedural revisions.
- Should definitive injuries occur, cases will be categorized using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-10-CM) coding classification.
- An incident report is an official record of incident and is privileged and confidential in all regards. No copies will be made of any incident report for any reason other than those situations authorized by applicable law.
13 CLAIMS AND REIMBURSEMENT PROCEDURES

Amerigroup Website and Provider Inquiry Line
We recognize that, in order to provide the best service to members, you need accurate, up-to-date information. You can access authorization status 24 hours a day, 365 days a year:

- Amerigroup provider website
- Availity.com
- Toll-free provider inquiry line

The Amerigroup website provides a host of online resources at https://providers.amerigroup.com/FL, featuring our online provider inquiry tool for authorization status. Detailed instructions for use of the online provider inquiry tool can be found on our website.

Our toll-free provider inquiry line, 1-877-440-3738, is available to help you check member status, claim status and authorization status. This option also offers the ability to be transferred to the appropriate department for other needs such as requesting new authorizations, checking on status, seeking advice in case management and contacting your account representative.

Claim Timely Filing
Paper and electronic claims must be filed so they are received within:

- Six months from the date of service for participating providers
- 365 days from the date of service for nonparticipating providers

Timely filing periods begin from the date of discharge for inpatient services and from date of service for outpatient/physician services.

There are exceptions to the timely filing requirements. They include:

- **Cases of coordination of benefits/subrogation** — For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date of the third party’s resolution of the claim.
- **Cases where a member has retroactive eligibility** — In situations of enrollment in Amerigroup with a retroactive eligibility date, the time frames for filing a claim will begin on the date we receive notification from the enrollment broker of the member’s eligibility/enrollment.

We will deny claims submitted after the filing deadline.

Documentation of Timely Claim Receipt
The following information will be considered proof that a claim was received timely. If the claim is submitted:

- **By U.S. mail:** First-class, return receipt requested or by overnight delivery service; you must provide a copy of the claim log that identifies each claim included in the submission.
- **Electronically:** You must provide the clearinghouse assigned receipt date from the reconciliation reports.
- **By fax:** You must provide proof of facsimile transmission.
• **By hand delivery:** You must provide a claim log that identifies each claim included in the delivery and a copy of the signed receipt acknowledging the hand delivery.

The claims log you maintain must include the following information:

- Name of claimant
- Address of claimant
- Telephone number of claimant
- Claimant’s federal tax identification number
- Name of addressee
- Name of carrier
- Designated address
- Date of mailing or hand delivery
- Subscriber name
- Subscriber ID number
- Patient name
- Date(s) of service/occurrence
- Total charge
- Delivery method

**Good Cause**

If a claim or claim appeal includes an explanation for the delay or other evidence that establishes the reason, we will determine good cause based primarily on that statement or evidence and/or if the evidence leads to doubt about the validity of the statement. We will contact you for clarification or additional information necessary to make a good cause determination.

Good cause may be found when a physician or supplier claim filing delay was due to:

- Administrative error: incorrect or incomplete information furnished by official sources (e.g., carrier, intermediary, Centers for Medicare & Medicaid Services CMS) to the physician or supplier.
- Incorrect information furnished by the member to the physician or supplier resulting in erroneous filing with another care management organization plan or with the state.
- Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the physician/supplier to secure such documentation or evidence.
- Unusual, unavoidable or other circumstances beyond the service provider’s control which demonstrate the physician or supplier could not reasonably be expected to have been aware of the need to file timely.
- Destruction or other damage of the physician’s or supplier’s records unless such destruction or other damage was caused by the physician’s or supplier’s willful act of negligence.

**Claims Submission**

We encourage the submission of claims electronically through Electronic Data Interchange (EDI). Participating providers must submit claims so that they are received within six months from the date of service, and nonparticipating providers must submit claims so that they are received within 365 days from the date of service. Electronic claims submission is available through:

- Emdeon — Claim payer ID 27514
- Capario — Claim payer ID 28804
- Availity — Claim payer ID 26375

The advantages of EDI submission include:

- Facilitates timely claims adjudication
- Acknowledges receipt and rejection notification of claims electronically
- Improves claims tracking
• Improves claims status reporting
• Reduces adjudication turnaround
• Eliminates paper
• Improves cost-effectiveness
• Allows for automatic adjudication of claims

The guide for EDI claims submission is located at https://providers.amerigroup.com/FL. The EDI claims submission guide includes additional information related to the EDI claim process.

To initiate the electronic claims submission process or obtain additional information, contact the Amerigroup EDI hotline at 1-800-590-5745.

**Website Submission**
Availity’s web portal will offer a variety of online functions to help you reduce administrative costs and gain extra time for patient care by eliminating paperwork and phone calls. You will need to sign up to access this new portal. Once signed up, you can log in to a single account and perform numerous administrative tasks for patients covered by Amerigroup or by other payers.

Claims can be submitted electronically through the Availity web portal. For more information about Availity such as how to register, training opportunities and more, visit www.availity.com or call 1-800-AVAILITY (1-800-282-4548).

**Paper Claims Submission**
Participating and nonparticipating providers also have the option of submitting paper claims. We use Optical Character Reading (OCR) technology as part of our front-end claims processing procedures. OCR technology is coupled with an imaging module to furnish providers with a more responsive claims processing interface. The benefits include:
• Faster turnaround times and adjudication
• Claims status availability within five days of receipt
• Immediate image retrieval by Amerigroup staff for claims information, allowing for more timely and accurate response to provider inquiries

In order to use OCR technology, claims must be submitted on original red claim forms (not black-and-white or photocopied forms) laser printed or typed (not handwritten) in a large, dark font. Participating providers must submit a properly completed CMS-1450 or CMS-1500 (08-05) form so it is received within six months from the date of service, and nonparticipating providers must submit the same forms so it is received within 365 days from the date of service.

In accordance with the implementation timelines set by CMS and by the National Uniform Claim Committee, we require use of the CMS-1500 (08-05) and CMS-1450 forms to accommodate your National Provider Identifier (NPI).

The CMS-1500 (08-05) or CMS-1450 form must include the following information (HIPAA-compliant, where applicable):
• Member ID
• Member name
• Days or units
• Provider tax ID number
• Member date of birth
• International Classification of Diseases, Ninth Revision (ICD-10) diagnosis codes/revenue codes
• Date of service
• Place of service
• Description of services rendered
• Itemized charges

• Provider name according to contract
• Amerigroup provider number
• NPI of billing provider when applicable
• State Medicaid ID
• Coordination of benefits/other insurance information
• Authorization/preauthorization number
• Any other state-required data

We cannot accept claims with alterations to billing information. Claims that have been altered will be returned with an explanation for the return. We will not accept claims from those providers who submit entirely handwritten claims.

Paper claims must be submitted to the following address:

Florida SMMC-LTC Claims
Amerigroup
P.O. Box 61010
Virginia Beach, VA 23466-1020

**International Classification of Diseases, 10th Revision (ICD-10) Description**

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements, and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9) which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across healthcare settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:
• Clinical modification (CM): ICD-10-CM is used for diagnosis coding
• Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.

**Roster**

Assisted living facilities and adult day health services can submit an Amerigroup-approved roster claim form. The roster claim form must be clean, free of alterations and complete. Alterations include using white-out and crossing out or writing over mistakes. This roster claim form must be faxed to 1-866-779-3031.
**Encounter Data**

We established and maintain a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must send encounter data to us for each member encounter. Encounter data can be submitted through EDI submission methods or on a CMS-1500 (08-05) claim form unless other arrangements are approved by Amerigroup. Data will be submitted in a timely manner, but no later than 180 days from the date of service. The encounter data will include the following:

- Member ID number
- Member name (first and last name)
- Member date of birth
- Provider name according to contract
- Amerigroup provider ID
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (using current procedure codes and modifiers if applicable)
- Provider tax ID number and state Medicaid ID number

Submit **encounter data** to the following address:

Amerigroup  
P.O. Box 61010  
Virginia Beach, VA 23466-1010

Our utilization and quality improvement staff monitors compliance, coordinates with the medical director and reports to the Quality Management Committee on a quarterly basis. We monitor the primary care provider for compliance with utilization reporting. Lack of compliance will result in training and follow-up audits and could result in termination from the network.

**Claim Adjudication**

All network and non-network provider claims submitted to Amerigroup for payment will be processed in accordance with F.S. 641.3155 according to Generally Accepted Claims Coding and Payment Guidelines. These guidelines are designed to comply with industry standards, as defined by the Current Procedural Terminology, Fourth Edition (CPT-4), ICD-10 and Resource-based Relative Value Scale (RBRVS) handbooks.

We use code-auditing software to comply with an ever-widening array of code edits and rules. Additionally, this review increases consistency of payment for providers by ensuring correct coding and billing practices are being followed. A sophisticated auditing logic determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes to process those services according to industry standards. The auditing software is updated periodically to conform to changes in coding standards and to include new procedure and diagnosis codes.
For questions regarding any edits that you receive on your explanation of payment, contact Provider Services at 1-800-454-3730.

For appropriate filing information, see CMS-1500 Claim Form Instructions and CMS-1450 Claim Form Instructions. Failure to provide any of the required information can result in payment being delayed. Timely filing of claims from participating providers must occur within six months of the date of service (180 days) and within 365 days for nonparticipating providers. We typically adjudicate claims submitted for payment under Amerigroup coverage within 15 days of submission for clean claims.
The rest of this page is left intentionally blank. Please proceed to the following pages.
BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDIARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 C.F.R. 411.24(a). If item 5 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and copayment services. Guarantees and the deductibles are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured", i.e., Items 1a, 4, 6, 7, 5, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnostic coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDIARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished in my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident to a physician's professional service," 1) they must be rendered under the physician's immediate personal supervision by his/her employee; 2) they must be an integral, although incidental part of a covered physician's service; 3) they must be of kinds commonly furnished in physician's offices; and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that (1) any employee who rendered services is not an active duty member of the Uniformed Services or civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5506). For Black Lung claims, I, the services were performed for a Black Lung-relate disorder.

Note: Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 442.32)

Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDIARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

PRIVACY ACT STATEMENT

We are authorized by CMS, CHAMPUS, and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is section 205(a), 1962, 1972, and 1974 of the Social Security Act as amended, 42 CFR 411.24(a) and 425.5(a)(5), and 44 USC 3101; 41 CFR 101 et seq; and 10 USC 7079 and 106; 8 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9307.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you requested are covered by these programs and to ensure that proper payment is made. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have received from a hospital or doctor. Additional disclosures are made through routine uses for information contained in records of systems.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55, No. 177, page 37549, Wed. Sept. 12, 1990, as it is updated and republished.


FOR CHAMPUS CLAIMS: PRINCIPAL PURPOSES: To evaluate eligibility for medical care provided by civilian sources and to sue payment upon establishment of eligibility and determination that the services supplied are authorized.

ROUTINE USES: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Department of Defense consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressmen in response to inquiries made on the request of the person to whom a record pertains. Appropriate disclosures may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care, in matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3671-3672 provide penalties for withholding this information.

You should be aware that P.L. 100-533, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICARE PAYMENTS PROVIDER CERTIFICATION

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by the Medicare program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1980, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0110. The time to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the estimated burden of information collection, or suggestions for improving the form, please write to CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-3599. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS. - 63 -
CMS-1450 Claim Form
This form is also available at www.CMS.gov.
Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this bill:

1. If third party benefits are indicated, the appropriate assignments by the insured beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.

5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1395I, 42 CFR 424.36, 10 USC 1071 through 1096, 32 CFR 190) and any other applicable contract regulations, is on file.

6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and has/his wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is required to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.

9. For TRICARE Purpose:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file.
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits.
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits.
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts, and
   (f) Any hospital-based physician under contract: the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

Based on 42 United States Code 1395c(a)(1)(i) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and

(h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SEE http://www.nubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS
Service Codes

When completing the CMS-1500 (08-05) form, ensure that the appropriate code listed below is noted in the Place of Service Code field.

<table>
<thead>
<tr>
<th>Place of Service Codes</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>11</td>
<td>Office</td>
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<tr>
<td>12</td>
<td>Home</td>
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<tr>
<td>20</td>
<td>Urgent care center</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient hospital</td>
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<tr>
<td>22</td>
<td>Outpatient hospital</td>
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<tr>
<td>23</td>
<td>Emergency room</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory surgery center</td>
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<td>31</td>
<td>Skilled nursing facility</td>
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<td>32</td>
<td>Other nursing facility</td>
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<td>33</td>
<td>Custodial care</td>
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<td>34</td>
<td>Hospice</td>
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<tr>
<td>99</td>
<td>Adult day care</td>
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<tr>
<td>45</td>
<td>Adult foster care</td>
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<tr>
<td>13</td>
<td>Assisted living/residential</td>
</tr>
<tr>
<td>53</td>
<td>Community mental health</td>
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<tr>
<td>61</td>
<td>Comprehensive inpatient rehabiliation</td>
</tr>
<tr>
<td>65</td>
<td>Dialysis center</td>
</tr>
<tr>
<td>81</td>
<td>Laboratory</td>
</tr>
</tbody>
</table>

Additional Notes
In addition, the following is required for claim adjudication:

- If an explanation of benefits statement from the primary payer to the secondary payer exists, attach it to the claim; this is not required if an electronic remittance notice was sent by the primary payer to the secondary payer.
- An itemized bill is required for any claim that meets or exceeds the stop-loss provision in the provider’s agreement with Amerigroup.
- Not Otherwise Classified (NOC) drugs require a description of the charges and National Drug Code (NDC) or a legible copy of the invoice dosage.
- If required by contract, utilize the appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code to define the procedure, service or supply.
RosterBillingForm

Statewide Medicaid Managed Care roster billing claims
☐ Managed Medical Assistance ☐ Long-term Care

Provider/Facility Name: _______________________________ Amerigroup Community Care Provider ID: ________________________

TIN/SSN: _______________________________ NPI: _______________________________ Medicaid ID: _______________________________

Provider/facility address:

<table>
<thead>
<tr>
<th>Member name</th>
<th>Amerigroup ID</th>
<th>Member DOB</th>
<th>Diagnosis code</th>
<th>Date(s) of service</th>
<th>Procedure code</th>
<th>Modifier</th>
<th>Unit</th>
<th>Charges</th>
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<tbody>
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Additional comments and/or changes to your contact information:

__________________________________________________________________________________________________________________________________________

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__________________________________________________________________________________________________________________________________________

Please fax this completed form to 1-866-779-3031
For questions, please call 1-800-600-4441 for MMA providers or 1-877-440-3738 for LTC providers.

Facility signature: _______________________________ Date signed: _______________________________ Phone number: _______________________________

This is not a guarantee of payment. Reimbursement of your medical claim is subject to the terms of the specific coverage including, but not limited to, member eligibility, plan policy limitations or exclusions, plan benefits, timely claims filing, and accurate billing of services. Benefits will be determined upon receipt of the claims. In order for claims to be processed accurately and in a timely manner, prior authorization for these services must be obtained. If you have any questions regarding authorized services, please contact your Amerigroup Community Care care coordinator.

Important Note: You are not permitted to use or disclose Protected Health Information about individuals that you are not currently treating or have enrolled to your practice. This applies to Protected Health Information accessible in any online tool or sent in any medium (including mail, email, fax or other electronic transmission).
Living Will (Florida Declaration)

On this __ day of ____, 20__, I, ___________________________ ___________________________ ___________________________ ___________________________, of my own free will, make known my desire that my dying not be artificially prolonged under any of the circumstances set out below, and I do hereby declare that:

Should I develop a terminal condition, and if my attending physician determines there can be no reasonable expectation of recovery from such a condition and my death is imminent, I hereby direct that life-prolonging procedures be withheld or withdrawn when such procedures serve only to artificially prolong the process of my dying. Under such circumstances, it is my desire that I be permitted to die naturally, with only the administration of such medication or the performance of any such medical procedure judged necessary to provide me with comfort and pain relief.

Relating to the administration of nutrition and hydration (food and fluids), I do / I do not (check one) desire that such be withheld or withdrawn when such procedures serve to only prolong in an artificial way the process of my dying. It is my intent that, should I be unable to give directions regarding the use of life-prolonging procedures, this represents the declaration of my intent and will be honored by my physicians, as well as by my family, as a valid representation of my legal right to refuse medical and/or surgical treatment and to accept the consequences as such.

I fully understand the important and consequences of this declaration. I am competent to make such declaration, and it is my desire to do so. I make this declaration without coercion and of my own free will.

If I am diagnosed as pregnant and that diagnosis is known to my physician, this declaration shall not be in effect during the course of my pregnancy.

Check one: □ I want to donate my organs. □ I do not want to donate my organs.

Signature: ___________________________ Date: ___________________________

Declaration of Witness:
The above is known to me, and it is my judgment that he/she is of sound mind and is making the above declaration of his/her free will.

Witness 1: ___________________________ Relationship: ___________________________

Witness 2: ___________________________ Relationship: ___________________________

Note: One witness should neither be a spouse nor a blood relative of the declarant, in compliance with Florida Statute 765, amended effective 10/1/90.
PF-FL-0002-11
Testamento Médico en Vida (Declaración de Florida)

En este día ___ de ___ de 20___, Yo, ____________________________ (Apellido) ____________________________ (Primer nombre) ____________________________ (Inicial del segundo nombre), por voluntad propia quiero manifestar (por escrito) mi deseo, de que mi vida no sea prolongada artificialmente bajo ninguna de las circunstancias dispuestas a continuación en este documento y por consiguiente declaro:

Si desarrollo una condición terminal y el médico que me atiende considera que no hay expectativa razonable de recuperación debido a esta condición y mi muerte es inminente, declaro directamente que los procedimientos para prolongar mi vida sean evitados o retirados cuando dichos procedimientos sirvan solamente para prolongar artificialmente el proceso de mi muerte. Bajo estas circunstancias, es mi deseo el que se me permita morir naturalmente, que solamente se me administren medicamentos o se ejecuten procedimientos que se juzguen necesarios para proveerme comodidad y aliviar el dolor. Con relación a la nutrición e hidratación (alimentos y fluidos) Yo deseo ___/Yo no deseo (marque una de las dos opciones) que estos procedimientos me sean negados o reservados cuando éstos solamente sirvan para prolongar de forma artificial el proceso de mi muerte. Es mi intención que si de alguna forma quedo impedido de dar las direcciones referentes a procedimientos de prolongar la vida, sea esta declaración la representación de mi intención que será honrada por mis médicos, así como mi familia como representación de mis derechos legales de rehusar tratamientos médicos y/o quirúrgicos y aceptar las consecuencias como tales.

Es de mi absoluto entendimiento la importancia y consecuencias de esta declaración y es mi deseo de que así sea. Hago esta declaración sin coacción y por voluntad propia.

Si llega a haber un diagnóstico de embarazo y mi médico tiene conocimiento del mismo, esta declaración no se hará efectiva durante el curso de mi embarazo.

Marque una de las dos opciones: ☐ Yo deseo donar mis órganos. ☐ Yo no deseo donar mis órganos.

Firma: ____________________________ Fecha: ____________________________

Declaración de Testigos:
Lo arriba escrito es de mi conocimiento y a mi juicio el/ella está en su sano juicio y está haciendo esta declaración voluntariamente.

Testigo 1: ____________________________ Relación: ____________________________

Testigo 2: ____________________________ Relación: ____________________________

Nota: Uno de los testigos no debe ser cónyuge o pariente consanguíneo del declarante de acuerdo con el Estatuto 765 de la Florida, enmienda efectiva 10/1/90.
Durable Power of Attorney (English)

In the event that my physician determines that I am incompetent or so incapacitated as to provide expressed and informed consent for medical treatment, surgical intervention or diagnosis procedures I, _______________ 

[Last Name] _______________ wish to designate the following person to make those decisions for me.

[First Name] _______________ [Middle Initial] _______________

DESIGNEE

NAME: ___________________________ TELEPHONE: ___________________________

ADDRESS: ___________________________ RELATIONSHIP (if any): ___________________________

ALTERNATE DESIGNEE

If the person that I have named is unable to act on my behalf I authorize the following person to act on my behalf:

NAME: ___________________________ TELEPHONE: ___________________________

ADDRESS: ___________________________ RELATIONSHIP (if any): ___________________________

I fully understand that this document will permit the above identified designee to support, withhold or withdraw consent for intended treatment and to do so on my behalf. That individual may also apply for public benefits to defer the cost of health care and authorize for my transfer to or from a health care facility.

I further reaffirm that this designation is not being made as a condition of treatment or admission to a health care facility. I understand, should my judgmental incapacitation or incompetence be reversed such that I am once again considered competent to make my own decisions, such decisions will once again be mine.

I understand that I may rescind this declaration at any time so long as I am judged to be competent and capable to make such judgements.

ADDITIONAL INSTRUCTIONS:

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

DO YOU HAVE A LIVING WILL DECLARATION?  ☐ Yes  ☐ No

SIGNATURE: ___________________________ DATE: ___________________________

WITNESS #1: ___________________________ DATE: ___________________________

WITNESS #2: ___________________________ DATE: ___________________________

NOTE: One witness should not be a spouse, blood relative, heir to the Estate of the designee or responsible for paying health care costs for that individual.
Durable Power of Attorney (Spanish)

Designación De Sustituto Para Decisiones Médicas

(PODER PARA DECISIONES DE ATENCIÓN MÉDICA)

En el caso de que mi médico determine que me encuentre incompetente e incapacitado al punto de no poder expresar o informar consentimiento para tratamientos médicos, intervenciones quirúrgicas o procedimientos de diagnóstico. Yo, ____________________________ (Apellidos, Primer Nombre, Inicial del Segundo Nombre) deseo designar a la siguiente persona para tomar estas decisiones por mi.

**DESIGNADO**

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<th>NOMBRE:</th>
<th>TELEFONO:</th>
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<td>DIRECCION:</td>
<td>RELACION:</td>
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**DESIGNADO ALTERNOS** Si la persona que he designado (nombrada) es incapaz de actuar en mi nombre, Yo autorizo a la siguiente persona para así hacerlo:

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<th>NOMBRE:</th>
<th>TELEFONO:</th>
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<tr>
<td>DIRECCION:</td>
<td>RELACION:</td>
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Yo entiendo perfectamente que este documento permitirá a la persona arriba identificada a apoyar, evitar o retirar consentimiento del tratamiento propuesto y de hacerlo en mi nombre. Este individuo puede también aplicar para beneficios públicos para defiinit los costos de atención de salud y autorizar mi transferencia hacia o desde una facilidad de atención de salud.

Yo reconozco más aún que esta designación no se ha tomado como condición de una facilidad de atención médica para recibir tratamiento o ser admitido. Entiendo que si mi capacidad de juicio o de incompetencia se reversa será considerado inmediatamente competente para tomar mis propias decisiones, estas decisiones serán otra vez mías.

Yo entiendo que puedo cancelar esta declaración en cualquier momento en que se determine que soy competente y capaz de discernir por mí mismo.

**INSTRUCCIONES ADICIONALES:**

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<th>INSTRUCCIONES ADICIONALES:</th>
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¿TIENE USTED UNA DECLARACIÓN DE TESTAMENTO EN VIDA?

☐ Sí  ☐ No

**FIRMA:**

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**TESTIGO #1:**

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**TESTIGO #2:**

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**NOTA:** Uno de los testigos no debe ser cónyuge, ni paciente consanguíneo, ni heredero único de las propiedades del designado o responsable de pagar costos de atención de salud para ese individuo.
Advance Directive (English)

I, ____________________________________________, have discussed the Living Will and

(Physician's Name)

Durable Power of Attorney with ________________________________.

(Member's Name)

___ Yes, the member has completed the Living Will and a copy will remain in his/her medical file.

___ Yes, the member has completed the Durable Power of Attorney and a copy will remain in his/her medical file.

___ No, the member declines to complete a Living Will.

___ No, the member declines to complete a Durable Power of Attorney.

______________________________
PHYSICIAN'S SIGNATURE:

______________________________
MEMBER'S SIGNATURE:
FECHA: ________________________________

Yo, ____________________________________________,
(Nombre del Médico)
he hablado con _________________________________________,
(Nombre del Miembro)
sobre lo que es un Testamento en Vida y un Potestad para Cuidado De Salud.

_____ Si, el miembro ha completado un Testamento en Vida y una copia se mantendrá en su archivo médico.

_____ Si, el miembro ha completado un Potestad para Cuidado De Salud y una copia se mantendrá en su archivo médico.

_____ No, el miembro rechaza completar un Testamento en Vida.

_____ No, el miembro rechaza completar un Potestad para Cuidado De Salud.

FIRMA DEL MÉDICO:

FIRMA DEL MIEMBRO: ________________________________
Grievance Form

Instructions:
If you wish to file a formal grievance, fill out, sign and return this form to the address at the bottom of this form. AMERIGROUP Community Care will look into your grievance and let you know the decision within 60 days from the time we get this form. You will get a letter letting you know AMERIGROUP has received your signed grievance.

By signing this form, you are letting AMERIGROUP get any medical records they need to look into your grievance.

MEMBER NAME: 

AMERIGROUP ID #: 

GRIEVANCE FILE #: 

Explain you grievance issues (please give dates and names and use extra sheets if needed):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Your Signature: 

Date: 

You may contact AMERIGROUP for help in completing this form. Call Member Services toll free at 1-800-950-7679.

AMERIGROUP Community Care  
ATTN: Grievance Coordinator  
4200 W. Cypress Street, Suite 900  
Tampa, FL 33607-4173
Instrucciones:

Si desea presentar un reclamo formal, complete, firme y envíe este formulario a la dirección que aparece al pie de esta carta. AMERIGROUP Community Care analizará su reclamo y le informará la decisión dentro de un período de 60 días a partir del momento en que recibamos este formulario. Recibirá una carta en la que se le informará que AMERIGROUP ha recibido su reclamo firmado.

Al firmar este formulario, usted permite que AMERIGROUP reciba cualquier registro médico que necesite para analizar su reclamo.

NOMBRE DEL MIEMBRO: ________________________________

NÚM. DE ID DE AMERIGROUP: __________________________

NÚM. DE EXPEDIENTE DE RECLAMO: ______________________

Explique el problema (proporcione fechas y nombres, y use hojas adicionales, de ser necesario):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Su firma: _____________________________________________________________

Fecha: ________________________________________________________________

Puede comunicarse con AMERIGROUP para recibir ayuda para completar este formulario. Llame a la línea gratuita de Servicios al Miembro al 1-800-950-7679.

AMERIGROUP Community Care
ATTN: Grievance Coordinator
4200 W. Cypress Street, Suite 900
Tampa, FL 33607-4173
Incident Report Form

**INCIDENT REPORT FORM**

**REPORT NUMBER** *(to be completed by Risk Manager only):*

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<thead>
<tr>
<th>NAME:</th>
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<tr>
<td>ADDRESS:</td>
<td>PHONE#:</td>
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<tr>
<td>DOB: / /</td>
<td>MARRIED: Yes No</td>
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<tr>
<td>GUARDIAN <em>(if applicable)</em>:</td>
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<tr>
<td>PRIMARY CARE PHYSICIAN:</td>
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<tr>
<td>INCIDENT <em>(brief, objective description)</em>:</td>
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**DESCRIPTION OF INCIDENT**

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<td>EXACT LOCATION:</td>
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<td>ICD-9-CM CODING INFORMATION <em>(to be filled out by the Risk Manager)</em>:</td>
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<tr>
<td>PHYSICIAN CALLED: Yes No</td>
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<td>PHYSICAL FINDINGS AND DIAGNOSIS:</td>
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<tr>
<td>MEDICAL RECOMMENDATIONS GIVEN:</td>
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