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About Magellan Complete Care

Magellan Complete Care is an integrated whole health plan designed for the total care of individuals including medical and behavioral health needs. Our clinical and operational model of care allows us to offer our members access to high-quality, clinically appropriate, affordable healthcare, tailored to each individual’s needs to ultimately improve healthcare outcomes and the overall quality of life for our members and their families.

Magellan Complete Care is a division of Magellan Health Services, a healthcare management company that focuses on fast-growing, complex and high-cost areas of healthcare, with an emphasis on special population management.

Model of Care

Our providers are the key to our success in meeting the needs of our members. Our model is built to meet the medical and behavioral healthcare needs of our members. The level of support and coordination is dependent on the needs of the individual members. Our Care Coordination Team (CCT) deploys a broad set of tools, resources and reports. The CCT is comprised of the member and/or designated representative, primary and specialist treating providers, an Magellan Complete Care Integrated Care Case Manager with both behavioral and physical health clinical expertise, peer support specialists, and a Health Guide. The Health Guide helps the member navigate through the physical and behavioral health delivery systems and ensures that the member receives all necessary behavioral and physical health services in order to live independently in the community.

Magellan Complete Care is a Medicaid specialty plan as part of the Statewide Medicaid Managed Care program specializing in the care of those with a Serious Mental Illness (SMI). Our members are both eligible for Medicaid and have been diagnosed with a Serious Mental Illness.

Magellan Complete Care brings the same commitment to the provider community that we have for the last 25-years. Together, we can leverage our strength, experience and expertise to improve outcomes for Medicaid recipients in our community.

Continuity of Care and Transition of Care Requirements

Magellan Complete Care and the other approved health plans will be following special procedures during the transition period. The transition period is defined as the first sixty (60) calendar days from the date of the member’s enrollment. Magellan works with in and out of network providers to assure the following:

- If the new member is receiving care which was prior authorized by the last health plan, or the member has ongoing treatment or medications, MCC will pay for those services without any form of authorization even if the providers or the pharmacy are not in our network.
- Members can continue to see their PCP and behavioral health provider until the new PCP and BH providers have reviewed and updated the member’s treatment plan (which should be within 60 days).
- An outreach program for all members using any historical claims and service authorization data provided by the State or previous health plans. We will use the data to identify and prioritize members who are at high risk if their behavioral or physical care is disrupted.
If our member experiences a problem finding providers or getting an appointment, our care workers, health guides, and other staff will trouble-shoot in real time.

Provider Services

Our Provider Support Representatives are committed to our providers and work to establish a positive experience with Magellan Complete Care including:

- Provide orientation to Magellan Complete Care
- Provide education and support to facilitate best practices and cultural competency
- Assist with strategies related to the development and management of the Magellan Complete Care provider network
- Support the processes that lead to resolution of operational short-falls (e.g. claims payment issues)
- Implement provider practice-based quality initiatives—(e.g. patient registries, P4P programs, provider scorecards)
- Distribute and review various Magellan Complete Care reports

Statewide Medicaid Managed Care Program

Medicaid is the medical assistance program that provides access to healthcare for low-income families and individuals. Medicaid also assists aged, blind and disabled people with the costs of nursing facility care and other medical expenses. Eligibility for Medicaid is usually based on the family’s or individual’s income and assets.

Florida has offered Medicaid services since 1970. Medicaid provides healthcare coverage for eligible children, seniors, disabled adults and pregnant women. It is funded by both the state and federal governments. The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as statewide Medicaid managed care (SMMC) and includes two programs: one for medical assistance (MMA) and one for long-term care (LTC).

The Agency for Healthcare Administration (AHCA) is responsible for administering the Statewide Medicaid Managed Care program. Magellan Complete Care is a participating specialty plan in the Statewide Medicaid Managed Care program.

Additional information regarding coverage and reimbursement can be found in the AHCA Medicaid handbooks and fee schedules. This information is available at www.fdhc.state.fl.us/medicaid/index.shtml.
Magellan Complete Care Participation Requirements

All participating providers with Magellan Complete Care must have a unique Florida Medicaid Identification Number, along with a National Provider Identification Number (NPI) and be credentialed by Magellan Complete Care. Magellan Complete Care does not employ or contract with individuals on the state or federal exclusions list.

Magellan Complete Care’s Network Development department ensures that all services and tasks related to the provider contract are performed in compliance with the terms of the Provider Agreement. The provider contract identifies any aspect of service that may be subcontracted by the provider.

In general, Magellan Complete Care only contracts with participating providers in the Medicaid fee-for-service program. Thus, a Level II background screening is performed through this program. Background screening is conducted by Magellan Complete Care in the event that other providers are contracted.

In this event, the background screen will be a Level II screen in accordance with Agency policies for providers not currently enrolled in the Medicaid fee-for-service program. This screen will require providers to submit fingerprints electronically through the Agency’s system, allow Magellan to exclude from contracting any provider who has a record of illegal conduct, and permit Magellan to receive verification of Medicaid eligibility through the background screening website. Providers who have completed a background screen through the Medicaid program or, within the last 12 months, by another Florida department are exempt from this requirement.
In order to assist you with your day-to-day operations, Magellan Complete Care has a team of experienced Customer Service, Provider Relations, Health Services and Pharmacy professionals to assist you with our plan. Please contact us whenever you need assistance.

<table>
<thead>
<tr>
<th>Department</th>
<th>Hours (M – F unless noted)</th>
<th>Telephone</th>
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<tbody>
<tr>
<td><strong>Provider Contacts</strong></td>
<td></td>
<td></td>
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<tr>
<td>Provider Services</td>
<td>8 a.m. to 7 p.m. ET</td>
<td>800-327-8613</td>
</tr>
<tr>
<td>Pharmacy Benefits</td>
<td></td>
<td>800-424-1694 TTY only</td>
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<tr>
<td>Claims</td>
<td></td>
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<tr>
<td>Network Development (Contracting)</td>
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<tr>
<td>Credentialing</td>
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<tr>
<td>Complaints</td>
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<tr>
<td>Check Member Eligibility</td>
<td>24 hours a day</td>
<td>800-327-8613</td>
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<tr>
<td></td>
<td></td>
<td>800-424-1694 TTY only</td>
</tr>
<tr>
<td><strong>Prior Authorizations and Referrals</strong></td>
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<tr>
<td>Health Services (Utilization Management)</td>
<td>24 hours a day</td>
<td>800-327-8613</td>
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<td></td>
<td></td>
<td>800-424-1694 TTY only</td>
</tr>
<tr>
<td><strong>Nurse Line</strong></td>
<td>24 hours a day</td>
<td>800-327-8613</td>
</tr>
<tr>
<td></td>
<td></td>
<td>800-424-1694 TTY only</td>
</tr>
<tr>
<td><strong>Member Contacts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Customer Service</td>
<td>8 a.m. to 7 p.m. ET</td>
<td>800-327-8613</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td></td>
<td>800-424-1694 TTY only</td>
</tr>
<tr>
<td>Condition Care Programs</td>
<td></td>
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<tr>
<td>Grievances and Appeals</td>
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<tr>
<td><strong>Vendor Contacts</strong></td>
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</tr>
<tr>
<td>Non-Emergent Transportation (Veyo)</td>
<td>Reservation line: 8 a.m. to 5 p.m. ET</td>
<td>800-424-8268</td>
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<tr>
<td></td>
<td>Transportation assistance for trip recovery and after hour discharges is available 24/7/365</td>
<td></td>
</tr>
<tr>
<td>Dental Services (DentaQuest)</td>
<td></td>
<td>800-964-7811</td>
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<tr>
<td>Routine and preventive vision (Florida Eye Care)</td>
<td>9 a.m. to 5 p.m. EST</td>
<td>877-481-3322</td>
</tr>
<tr>
<td>Routine and preventive vision (Premiere Eye)</td>
<td>24 hours a day</td>
<td>800-738-1889</td>
</tr>
<tr>
<td>Hearing Evaluations (HearUSA)</td>
<td>8 a.m. to 8 p.m., voice mail after hours</td>
<td>800-528-3277</td>
</tr>
<tr>
<td><strong>State Contacts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FL Department of Children and Families</td>
<td>8:00 am to 5:00 pm ET</td>
<td>866-762-2237</td>
</tr>
</tbody>
</table>
Member Eligibility and ID Card

Magellan Complete Care requires that our members keep their ID card with them at all times. If a member loses their ID card, please have them contact Customer Service toll free at 800-327-8613. If they’re hearing impaired, call toll free at 800-424-1694 TTY. Magellan Complete Care will send them a replacement ID card within 5 business days.

Please remember that a member ID card is not a guarantee of payment for services rendered. The provider’s office is responsible for verifying eligibility at the time of each office visit. The provider can access the following methods to verify eligibility:

- Call 24-hour Eligibility Line at 800-327-8613
- Online at MCCofFL.com

*ID Card front:*

Member Name: xxxMEMBERNAMExxx
Member #: xxMEMBERNBR-xx
Group: xxxxx
Enrollment Date: xx/xx/xxxx

Utilize Medicaid Participating Pharmacies
BIN #: 016523  PCN #: 622  RxGroup: XXXXXXX

*ID Card back:*

Customer Service, Claims/Billing, and Transportation:
1-800-327-8613 (Monday – Friday 8 a.m. – 7 p.m. EST)
If you are hearing impaired, call our TTY number at 1-800-424-1694
Emergency Services: Seek treatment at the nearest emergency room or urgent care center or call 911. Notify your doctor and the health plan within 48 hours or as soon as possible if you are admitted to the hospital.

Authorizations/Eligibility (Participating and Non-Participating Providers):
1-800-327-8613

Mail Claims to:  Magellan Complete Care
PO Box 2097
Maryland Heights, MO 63043

Payor ID#: 01260

Possession of an ID card does not guarantee eligibility or payment for services provided.
PCP Responsibilities

With the support of the Magellan Complete Care’s Core Care team, the primary care provider (PCP) is responsible for the overall care of the member. This includes providing direct care, referring members for behavioral health, specialty or ancillary care and coordinating care with the health plan and these providers for greater clinical outcomes.

Coordination of Care

- **Coordinator of Care:** The PCP is the coordinator of care. Therefore, the PCP agrees to ensure continuity of care for Magellan Complete Care’s members and arranges for the provision of services when the PCP’s office is not open. The PCP integrated medical record should include documentation of the member’s care, and the treatment plan, including documentation of ER visits, lab results, hospital discharge summaries or operative reports.

- **Sharing of Information:** The PCP agrees to facilitate adequate and timely communication among providers and the transfer of information when members are transferred to other healthcare providers.

- **Agency Communication:** The PCP agrees to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide quality care.

- **OB/GYN as PCP:** Each female member may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the Magellan Complete Care network. Please call Magellan Complete Care at 800-327-8613 if a member makes this request.

Access and Availability

- **Member Panel:** The PCP agrees to maintain a ratio of members to full time equivalent (FTE) physicians as follows:
  - One physician shall not exceed a Magellan Complete Care member panel of 1,500; each physician extender (ARNP or PA) may increase panel size by 750 patients.
  - The PCP must certify to Magellan Complete Care whether or not their active member panel exceeds 3,000 across all plans during the application and re-credentialing process.

Referrals

Consistent with our model of care, Magellan Complete Care has established a referral policy which promotes care coordination, integration, and access. We do not require in-network referrals to be approved by the health plan; however, provider’s records are expected to include evidence that care has been coordinated among the member’s treating providers.

Specifically, primary care providers should refer the member for specialty care and send their NPI number, clinical records and other relevant information to the specialist at the time of the referral, in advance of the appointment. Specialists are expected to provide a written report to the primary care provider after seeing the member. All Magellan Complete Care providers are expected to maintain medical records which reflect this coordination. If coordination is oral, the providers’ records should include documentation of the communication.
We require specialists to include the primary care provider’s NPI number in field 17b on claims for office-based services. Exceptions to this requirement include:

- Provider is in the same provider group, or has the same tax ID or type II NPI as the referring physician.
- Services were provided after hours (99050)
- Emergency services (services performed in place of service 23)
- Obstetrics/gynecology claims
- Billing or referring physician is from any of the following:
  - Federally Qualified Health Center
  - Urgent Care Center
  - County Health Departments
- Self-referrals—Members may self-refer for certain services, including:
  - Family planning services
  - Annual eye exams by optometrist
  - Some chiropractic, podiatric, and dermatologic services
  - Well-woman examinations
  - Behavioral health services

For these excluded services, Magellan Complete Care requests your assistance in communicating and coordinating the care of members. However, we pay for direct-access services without completion of field 17b.

If medically necessary care cannot be provided by in-network providers, care can be provided by an out-of-network provider. In these exceptional cases, Magellan Complete Care requires prior authorization by the health plan.

Provision of Assessment and Counseling Services

- **Initial Assessment**: The PCP must conduct a health assessment of all new members within 90 days of the effective date of enrollment. The PCP is responsible for notifying Magellan Complete Care if unable to contact the member to arrange the initial assessment with 90 days.
- **Members Entering Protective Custody**: The PCP agrees to physically screen members taken into the Protective Custody, Emergency Shelter or Foster Care programs by the Department of Children and Families (DCF) within 72 hours or immediately, if required.
Provider Responsibilities (including PCPs)

Pregnancy

- **Pregnancy Identification**: The provider is responsible for notifying Magellan Complete Care’s Health Services team when they identify a pregnant member at 800-327-8613. If faxed, the notification should include the member’s name, ID number, and due date.

- **Referrals to Healthy Start and WIC**: The provider agrees to refer pregnant women or infants to Healthy Start and WIC programs.

- **HIV Counseling for Pregnant Women**: The provider agrees to provide counseling and offer the recommended anti-retroviral regimen to all pregnant women who are HIV-positive and to refer them and their infants to Healthy Start programs, regardless of their screening scores.

- **Hepatitis B Screening for Pregnant Women**: The provider agrees to offer screening for Hepatitis B surface antigen to all women receiving prenatal care. If they test positive, the provider agrees to refer them to Healthy Start regardless of their screening score and to provide Hepatitis B Immune Globulin and the Hepatitis B vaccine series to children born to such mothers.

Access and Availability

- **24-Hour Coverage**: All providers must provide 24 hours a day/seven days a week coverage and regular hours of operation must be clearly defined and communicated to the members, including arranging for on-call and after-hours coverage. Such coverage must consist of an answering service, call forwarding, provider call coverage or other customary means approved by Magellan Complete Care per AHCA guidelines. The after-hours coverage must be accessible using the medical office’s daytime telephone number and the call must be returned within 30 minutes of the initial contact.

- **Coverage During Absence**: The provider must arrange for coverage of services during absences due to vacation, illness, or other situations that require the provider to be unable to provide services. A Magellan Complete Care participating provider must provide coverage.

- **Appointment Wait Time Requirement**: The provider offers appointments to our members within the timeframes outlined below. Please ensure office staff is aware of and follows these standards. Magellan Complete Care audits its providers on a routine basis to ensure that your offices are compliant with this policy.
  - Urgent Care—within one day
  - Routine Sick Patient Care—within one week
  - Well Care Visit—within one month

- **Timely Medical Evaluation**: The provider will ensure that all patients have a professional evaluation within one hour of their scheduled appointment time. If a delay is unavoidable, the patient will be informed and provided an alternative.

- **Americans with Disability Act**: The provider agrees to establish appropriate policies and procedures to fulfill obligations under the Americans with Disabilities Act (ADA).
Claims Submission

- To ensure timely payment, participating providers must submit clean claims and/or encounters using the methodology established by AHCA for that provider and service except as outlined in this manual. This also ensures that the required Magellan Complete Care encounter data will be accepted by the Florida MMIS and/or the State’s encounter data warehouse.
- The provider agrees to submit a claim or encounter using the correct codes for each preventative visit. These claims provide the documentation needed for gaps in care for our members and for HEDIS (Health Plan Employer Data and Information Set) service.

Medical Records

- **Participation in Medical Record Sharing:** The provider must adhere to Magellan Complete Care release of medical records policy to facilitate the sharing of medical records (subject to applicable confidentiality requirements in accordance with 42 CFR, Part 431, Subpart F, including a minor’s consultation, examination and drugs for STDs in accordance with Section 384.30 (2), F.S.).
- **Confidentiality of Member Records:** The provider must comply with all applicable federal and state laws regarding the confidentiality of member records.
- **Release of Medical Records:** The provider agrees to obtain a signed and dated release allowing for the release of information to Magellan Complete Care and other providers involved in the member’s care.
- **Release of Information on Sensitive Conditions:** Release of information about protected and sensitive conditions and services, including psychotherapeutic services, requires specific release from the member prior to sharing with other providers. The Magellan Complete Care Authorization to Use and Disclose Protected Health Information (AUD) form is used to indicate the conditions for which release is permitted. This form can be found at MagellanCompleteCareofFL.com.
- **Notations for Clinical Research:** The provider agrees that any notation in a member’s clinical record indicating diagnostic or therapeutic intervention as part of clinical research will be clearly contrasted with entries regarding the provision of non-research related care.
- **Sharing of Immunization Information:** The provider agrees to provide immunization information to the DCF upon receipt of member’s written permission and DCF’s request for members requesting temporary cash assistance from the DCF.
- **Obtaining Records from Out-of-Network Providers:** The provider agrees to attempt to obtain medical records on any member(s) receiving services from a non-network provider using the proper release signed by the member.
- **See Medical Records section for additional information.**
Network Development

- **New Provider in Group Practice:** If a new provider is added to a group, Magellan Complete Care must approve and credential the provider before the provider may treat members unless a prior authorization has been approved. Notification of changes in the provider staff is the responsibility of the provider’s office and must be communicated to Magellan Complete Care Network Development in writing to the following address:

  Network Management Contract Administration Florida MHS, Inc.
  14100 Magellan Plaza
  Maryland Heights, MO 63043

- **Malpractice Insurance:** The provider is required to maintain malpractice insurance acceptable to Magellan Complete Care. This information is verified by obtaining a copy of the malpractice insurance fact sheet from the provider or from the malpractice insurance carrier. If the provider does not carry malpractice insurance (“going bare”), the provider must conform to the notification requirements contained in Section 458.320, F.S.

Credentialing

Providers are required to successfully complete the Magellan Complete Care credentialing process prior to seeing Magellan patients. As part of the credentialing and re-credentialing process, Magellan Complete Care will identify, evaluate and verify Provider education and experience through the primary source verification.

Providers must meet all Magellan Complete Care credentialing and re-credentialing requirements, be aware of any applicable state licensing and credentialing laws and their malpractice policy regarding care for members residing in a different state or region. Providers should ensure the information provided through CAQH is updated in a timely manner and is current.

Providers have the right to review information submitted to support their credentialing application. Upon review of this information providers have the ability to correct any erroneous information.

Providers have the right to receive status for their credentialing or recredentialing application upon written request.

Appealing Decisions That Affect Network Participation Status

Participating providers have a right to appeal Magellan Complete Care quality review actions that are based on issues of quality of care or service that impact the conditions of the provider’s participation in the network. Client requirements and applicable federal and state laws may impact the appeals process; therefore, the process for appealing is outlined in the written notification that details the changes in the conditions of their participation due to issues of quality of care or services.

Participating providers are offered an opportunity for formal appeal hearing when Magellan Complete Care has taken action to terminate network participation due to quality concerns. These providers are notified in writing of the action. Notification includes: the reason(s) for the action; the right to request an appeal; the process to initiate a request for appeal; summary of the appeal process; and that such request must be made within thirty-three (33) calendar days from the date of Magellan’s written notification.
Providers may participate in the appeal hearing either telephonically or in-person and may be represented by a person of the provider’s choice. Providers are notified in writing of the appeal decision within thirty (30) calendar days of completion of the formal appeal hearing. Specifics of the appeal and notification processes are subject to customer, state or Federal requirements.

Professional providers whose network participation is terminated due to license sanctions or disciplinary action or exclusion from participation in Medicare, Medicaid or other Federal health care programs are offered an internal administrative review only, unless otherwise required by customer, state or Federal requirements. Providers are notified in writing of their network participation status, reason for denial of ongoing participation, and informed of their right to an internal administrative review. Providers are permitted no more than thirty-three (33) calendar days from the date of Magellan’s written notification to request an administrative review if they disagree with the reasons for the termination. The provider is notified in writing of the outcome within thirty (30) calendar days of the administrative review.

Quality

- **Quality Program Participation:** The provider agrees to participate and cooperate with Magellan Complete Care in quality management, utilization review, continuing education, peer review and other similar programs established by Magellan Complete Care to provide quality care in a responsible and cost-effective manner.

- **Exposure Control Plan:** The provider agrees to develop and have an exposure control plan in compliance with OSHA standards regarding blood borne pathogens.

- **Minimizing Transmission of Infection:** The provider agrees that provisions will be made to minimize sources and transmission of infection.

- **Use and Exchange of Data:** Providers agree to allow Magellan Complete Care to use all performance and claims data for reasons such as quality improvement activities. Magellan Complete Care will monitor the quality and performance of each provider by evaluating using specific metrics. These metrics will be communicated to the network prior to implementation or changes. Magellan Complete Care will share appropriate data in support of these calculations with providers as appropriate and, from time to time, may request additional ad hoc data from providers to support these measures.

- **Provide Care According to the most recent clinical practice guidelines for psychiatric, medical, surgical, mental health and substance abuse treatment:** Providers must provide care based on most recent peer reviewed standards: These standards with associated tip sheets can be found on our provider portal and will be routinely updated per Magellan Complete Care guidelines. Refer to our website under Provider Tools/Quality Initiatives.

- **Participate in interdisciplinary care plan meeting:** It is the expectation that providers participate in these meetings in order review and discuss complex cases requiring coordination and targeted care planning. Attending these meetings are important aspect of Magellan Complete Care’s care coordination and case management functions.
Retrospective/Post Service Review Process

A retrospective/post-service request is defined as a request for coverage of medical care or services that has been received without an authorization on file. Retrospective decisions are made within 30 calendar days from receipt of the request and are based on the clinical information submitted at the time of the request.

Please note the following important information:

• Magellan Complete Care does not accept Retrospective/Post-Service review requests submitted directly to the Health Services (UM) Department without record of a previous claim denial.

• Hospitals are required to notify the Plan of all emergency inpatient admissions within 24 hours but no later than ten (10) days from date of admission. For notifications after 10 days from date of admissions for members who have already been discharged, hospitals must submit a claim with medical records. Once the claim with medical records has been received, the claim will be denied for no authorization and the medical records will be submitted to the Health Services Department to review for medical necessity. If the claim is submitted without medical records, the hospital must submit the medical records pursuant to the instructions on the EOP. In order to expedite this process, when submitting medical records after your claim has been denied, please submit a copy of your EOP or Claim with your medical records.

• In network non-hospital providers are expected to submit a pre-service authorization request to the Plan prior to providing the service or care. For services that require an authorization, claims submitted for services provided without prior authorization will be denied.

Claims can be submitted to:
Magellan Complete Care of Florida
PO Box 2097
Maryland Heights, MO 63043
Payer ID#: 01260
Please call us at 1-800-327-8613 with any questions or concerns.

Grievances and Appeals

The provider agrees to participate in and cooperate with Magellan Complete Care grievance and appeal procedures when Magellan Complete Care notifies the provider of any member complaints or grievances. Refer to Grievances and Appeals section for more information.

Balance Billing

The provider cannot balance bill any member for a covered service. Magellan Complete Care is waiving member co-pays.

Provision of Assessment and Counseling Services

• HIV Counseling: The provider agrees to provide HIV counseling and offer HIV testing to all members of childbearing age.
Newborn Hearing Screening

Magellan Complete Care requires all newborns to receive a hearing screening from an audiologist per AHCA guidelines. All screenings must be completed prior to hospital discharge after birth, unless appropriate communication has been provided to Magellan Complete Care. Follow-up visits should be scheduled if necessary based on the results of the screening. The appropriate written documentation of service (or referral if necessary) must be placed in the recipient’s medical record within 24 hours after the provider completes the screening procedure or within 24 hours of the parent’s or guardian’s signed refusal of screening. This information should be provided directly to the PCP as the coordinator of care.

The documentation must include the following:
• Type of screen test administered, date of test, and tester’s name
• Results
• Interpretation
• Recommendations
• Follow-up referrals for treatment, if applicable
• Parent’s or guardian’s refusal of screening, if applicable

Identifying and Reporting Abuse, Neglect, or Exploitation

You can report abuse, neglect, or exploitation by calling the abuse hotline at 800-96-ABUSE. The Florida Abuse Hotline serves as the central reporting center for allegations of abuse, neglect, and/or exploitation for all children and vulnerable adults in Florida.

The Florida Abuse Hotline will accept a report when:
• There is reasonable cause to suspect that a child who can be located in Florida, or is temporarily out of the state but expected to return in the immediate future, has been harmed or is believed to be threatened with harm from a person responsible for the care of the child OR
• Any vulnerable adult who is a resident of Florida or currently located in Florida who is believed to have been abused or neglected by a caregiver in Florida, or suffering from the ill effects of neglect by self and is in need of service, or exploited by any person who stands in a position of trust or confidence, or any person who knows or should know that a vulnerable adult lacks capacity to consent and who contains or uses, or endeavors to obtain or use, their funds, assets or property. Abuse can be reported by calling the Florida Abuse Hotline, which is available statewide, toll-free telephone number, at 1-800 96-ABUSE (1-800-962-2873).
Marketing/Community Outreach Activities

Providers are required to comply with all state provisions and those in the Magellan Complete Care contract related to Marketing requirements. The primary restrictions are summarized below.

To the extent that a provider can assist a recipient in an objective assessment of his/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:

a. Offer marketing/appointment forms.

b. Make phone calls or direct, urge or attempt to persuade recipients to enroll or disenroll in the Managed Care Plan based on financial or any other interests of the provider.

c. Mail marketing materials on behalf of the Managed Care Plan.

d. Offer anything of value to induce recipients/enrollees to select them as their provider.

e. Offer inducements to persuade recipients to enroll in the Managed Care Plan.

f. Conduct health screening as a marketing activity.

g. Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.

h. Distribute marketing materials within an exam room setting.

i. Furnish to the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan.

Providers may:

a. Provide the names of the Managed Care Plans with which they participate.

b. Make available and/or distribute Managed Care Plan marketing materials.

c. Refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office.

d. Share information with patients from the Agency’s website or CMS’ website.

Provider Affiliation Information

a. Providers may announce new or continuing affiliations with the Managed Care Plan through general advertising (e.g., radio, television, websites).

b. Providers may make new affiliation announcements within the first thirty (30) calendar days of the new provider agreement.

c. Providers may make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone.

d. 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 contracts.

e. Any affiliation communication materials that include Managed Care Plan-specific information (e.g., benefits, formularies) must be prior approved by the Agency.
Risk Management and Adverse/Critical Incident Reporting

Risk management is a collaborative effort managed under the QI Program structure in conjunction with other Magellan Complete Care departments including Compliance and Legal. The goal of the program is to accomplish early identification of potential or existing risk in order to eliminate or mitigate risks to members and Magellan Complete Care. To support this goal, the Risk Management Program incorporates the following components:

- A full-time employed designated Compliance Officer. The Compliance Officer is qualified by knowledge, training and experience in health care or risk management to promote, implement and oversee the compliance program.
- Investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to members;
- Development of appropriate measures to minimize the risk of injuries and adverse incidents to patients, including risk management and risk prevention education and training of personnel as follows:
  - Incorporated into initial orientation; and
  - A minimum of 1 hour of education and training annually for personnel of the organization who work in clinical departments and support care and services to members;
- Analysis of member grievances related to patient care and the quality of medical services; and
- Development and implementation of an incident reporting system based upon the affirmative duty of all providers and all agents and employees of the organization to report injuries and adverse incidents to the risk manager.

- Procedures and internal controls intended to reduce the frequency and severity of medical malpractice and patient injury claims.
- Training of employees and practitioners to report and file adverse incident reports with the Risk Manager to include reporting of incidents to the Risk Manager
- Use of adverse incident reports to develop categories of incidents which identify problem areas.
- Processes to correct identified problem areas.
- Timely reporting to the Agency for Healthcare Administration of adverse incidents/untoward events which result in death of a patient, severe brain or spinal damage to a patient, a surgical procedure being performed on the wrong patient, or a surgical procedure unrelated to the patient’s diagnosis on medical needs being performed on any patient.
- Provision of routine (at least quarterly) summary reports to the Magellan Complete Care governing board.

Adverse and Critical Incident Reports

Adverse Incidents are unexpected occurrences in connection with services that led to or could have led to serious unintended or unexpected harm, loss or damage, such as death or serious injury, major medication incidents, exploitation, abuse, or neglect to an individual receiving service through Magellan Complete Care or a third party that becomes known to Magellan Complete Care staff.

Magellan Complete Care, has developed and implemented an incident reporting and management system for adverse or critical incidents. This plan requires participating
providers and direct service providers to report adverse or critical incidents to the Magellan Complete Care within 48 hours.

Magellan Complete Care does not require provider submission of adverse incident reports from the following providers: health maintenance organizations and health care clinics reporting in accordance with s. 641.55, F.S.; ambulatory surgical centers and hospitals reporting in accordance with s. 395.0197, F.S.; assisted living facilities reporting in accordance with s. 429.23, F.S.; nursing facilities reporting in accordance with s. 400.147, F.S.; and crisis stabilization units, residential treatment centers for children and adolescents, and residential treatment facilities reporting in accordance with s. 394.459, F.S. Adverse incidents occurring in these licensed settings shall be reported in accordance with the facility’s licensure requirements.

When an adverse incident is identified, the provider completes the Magellan Complete Care Adverse Incident Report and mails it to the address indicated on the form or calls Magellan Complete Care’s Health Services Risk Manager or Quality Department. If you call to report the information, please be prepared to provide all information listed on the form. Incidents related to (a) the death of a patient, (b) severe brain or spinal damage to a patient, (c) a surgical procedure being performed on the wrong patient, or permanent disfigurement, or (d) a surgical procedure unrelated to the patient’s diagnosis or medical needs being performed on any patient must be reported within 24 hours of the incident. All other incidents should be reported as soon as possible. A fracture or dislocation of bones or joints must be reported within 48 hours of the incident or at the provider’s knowledge of the incident.

Other reportable adverse incidents include any condition(s):

- Requiring medical attention which is not consistent with the routine management of the patients’ case or pre-existing physical conditions,
- Requiring surgical intervention to correct or control,
- Resulting in transfer of the patient within or outside of the facility, to a unit providing a more acute level of care,
- Extending the patient’s length of stay; or
- Resulting in a limitation of neurological, physical or sensory function which continues after discharge from a facility.

Magellan Complete Care provides appropriate training and takes corrective action as needed to ensure its staff, participating providers, and direct service providers comply with critical incident reporting requirements.

As part of this plan, Magellan Complete Care, will report to the Department of Children and Families’ Central Abuse Hotline any suspected cases of abuse, neglect or exploitation of enrollees, in accordance with s.39.201 and Chapter 415, F.S. Magellan Complete Care maintains documentation related to the reporting of such events in a confidential file, separate from the enrollee’s case file. Such file shall be made available to the Agency upon request.

Magellan Complete care, reports a summary of adverse and critical incidents to the Agency, as specified in Section XIV, Reporting Requirements, in the manner and format determined by the Agency.
Magellan Complete Care does not tolerate fraud, waste or abuse, either by providers or staff. Accordingly, we have instituted extensive fraud, waste and abuse programs to combat these problems. Magellan Complete Care’s programs are wide-ranging and multi-faceted, focusing on prevention, detection and investigation of all types of fraud, waste and abuse in government programs and private insurance.

Magellan Complete Care’s expectation is that the provider will fully cooperate and participate with its fraud, waste and abuse programs. This includes, but is not limited to, permitting Magellan Complete Care access to member treatment records and allowing Magellan Complete Care to conduct on-site audits or reviews. Magellan Complete Care also may interview members as part of an investigation, without provider interference.

Our policies in this area reflect that both Magellan Complete Care and providers are subject to federal and state laws designed to prevent fraud and abuse in government programs (e.g., Medicare and Medicaid), federally funded contracts and private insurance. Magellan Complete Care complies with all applicable laws, including the Federal False Claims Act, state false claims laws (see State-Specific Information on our website), applicable whistleblower protection laws, the Deficit Reduction Act of 2005, the American Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act of 2010 and applicable state and federal billing requirements for state-funded programs, federally funded programs (e.g., Medicare Advantage, SCHIP and Medicaid) and other payers. Visit our website to review these policies at http://magellanhealth.com/our-edge/clinical-excellence/compliance/dra-compliance-statement.aspx.

The provider’s responsibility is to
• Comply with all laws and Magellan Complete Care requirements
• Comply with all federal and state laws regarding fraud, waste and abuse
• Provide and bill only for medically necessary services that are delivered to members in accordance with Magellan’s policies and procedures and applicable regulations
• Ensure that all claims submissions are accurate
• Notify Magellan Complete Care immediately of any suspension, revocation, condition, limitation, qualification or other restriction on the provider’s license, or upon initiation of any investigation or action that could reasonably lead to a restriction on the provider’s license, or the loss of any certification or permit by any federal authority, or by any state in which you are authorized to provide healthcare services

Definitions—Fraud, Waste and Abuse

• Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable federal or state law.

• Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to government-sponsored programs, and other healthcare programs/plans, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for
healthcare. It also includes recipient practices that result in unnecessary cost to federally and/or state-funded healthcare programs, and other payers.

- **Waste** means over-utilization of services or other practices that result in unnecessary costs.

Some examples of potential fraud, waste and abuse include:

- Billing for services or procedures that have not been performed or have been performed by others
- Submitting false or misleading information about services performed
- Misrepresenting the services performed (e.g., up-coding to increase reimbursement)
- Retaining and failing to refund and report overpayments (e.g., if your claim was overpaid, you are required to report and refund the overpayment, and unpaid overpayments also are grounds for program exclusion)
- A claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim under the False Claims Act;
- Providing or ordering medically unnecessary services and tests based on financial gain
- An individual provider billing multiple codes on the same day where the procedure being billed is a component of another code billed on the same day (e.g., a psychiatrist billing individual therapy and pharmacological management on the same day for the same patient)
- An individual provider billing multiple codes on the same day where the procedure is mutually exclusive of another code billed on the same day (e.g., a social worker billing two individual psychotherapy sessions on the same day for the same patient)
- Providing services over the telephone or Internet and billing using face-to-face codes
- Providing services in a method that conflicts with regulatory requirements (e.g., exceeding the maximum number of patients allowed per group session)
- Treating all patients weekly regardless of medical necessity
- Routinely maxing out of members’ benefits or authorizations regardless of whether or not the services are medically necessary
- Inserting a diagnosis code not obtained from a physician or other authorized individual
- Violating another law (e.g., a claim is submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital such as a physician receiving kickbacks for referrals)
- Submitting claims for services ordered by a provider that has been excluded from participating in federally and/or state-funded healthcare programs
- Lying about credentials, such as degree and licensure information
Report Suspected Fraud, Waste or Abuse

Magellan Complete Care expects providers and their staff and agents to report any suspected cases of fraud, waste or abuse. Magellan Complete Care will not retaliate against the provider if he/she informs Magellan, the federal government, state government or any other regulatory agency with oversight authority of any suspected cases of fraud, waste or abuse.

Report to Magellan Complete Care

Reports of fraud, abuse or waste should be made to Magellan Complete Care via one of the following methods:

- National Special Investigations Unit Hotline: 1-800-755-0850
- Florida Special Investigation Unit Hotline: 1-877-269-7624
- Special Investigations Unit Email: SIU@MagellanHealth.com
- Corporate Compliance Hotline: 1-800-915-2108
- Compliance Unit Email: Compliance@MagellanHealth.com

Reports to the Corporate Compliance Hotline may be made 24 hours a day/seven days a week. The hotline is maintained by an outside vendor. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

You can also report suspected cases of fraud, waste, abuse, and overpayments directly to the agencies listed below:

- Bureau of Medicaid Program Integrity—To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at: https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx
- Florida Office of the Attorney General Medicaid Fraud Control Unit at 1-866-966-7226—If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other healthcare provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free 1-866-966-7226 or 850-414-3990). The reward may be up to 25 percent of the amount recovered, or a maximum of $500,000 per case (Florida Statutes Chapter 409.9203). You can talk to the Attorney General's Office about keeping your identity confidential and protected.
- Florida Department of Financial Services Division of Insurance Fraud: Contact the DFS Fraud Hotline at 1-800-378-0445
- U.S. Department of Health & Human Services Office of Inspector General: Contact the Office of the Inspector General by phone, fax, email, or by mail.

U.S. Department of Health & Human Services Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026
Telephone: 1-800-HHS-TIPS (1-800-447-8477)
Fax: 1-800-223-8164
Email: HHSTips@oig.hhs.gov
Consistent with federal and state requirements, any individual or entity excluded from participation in federally or state-funded contracts and programs cannot participate in any federally or state-funded healthcare program. Magellan Complete Care's policy is to ensure that excluded individuals/entities are not hired, employed or contracted by Magellan Complete Care to provide services for any of Magellan's product offerings.

The provider’s responsibilities as required by the Centers for Medicare and Medicaid Services (CMS), further protects against payments for items and services furnished or ordered by excluded parties. If the provider participates in federally funded healthcare programs, he/she must take the following steps to determine whether their employees and contractors are excluded individuals or entities:

- Screen all employees, agents and contractors to determine whether any of them have been excluded. Providers are required to comply with this obligation as a condition of enrollment as a Medicare or Medicaid provider.
- Search the HHS-OIG LEIE website at www.oig.hhs.gov/ to capture exclusions and reinstatements that have occurred since the last search. Providers can search the website by individual or entity name.
- Immediately report to the respective state Medicaid Agency and Magellan Complete Care any exclusion information discovered.

To comply with Magellan Complete Care’s fraud, waste and abuse programs, the provider’s responsibility is to:

- Prior to contracting/hiring and monthly thereafter, check to ensure that the provider, your employees, agents, directors, officers, partners or owners/person with a 5 percent or more controlling interest and subcontractors are not debarred, suspended, terminated, or otherwise excluded under the HHS-OIG LEIE at http://www.oig.hhs.gov/, the General Services Administration’s System for Award Management (SAM) Exclusions Database (http://www.sam.gov/), the Florida Sanctioned and Terminated Provider List (https://apps.ahca.myflorida.com/dm_web), and any other applicable state exclusion list where the services are rendered or delivered; and immediately notify Magellan Complete Care in writing of the debarment, suspension or exclusion of the provider, the provider’s employees, agents, subcontractors, directors, officers, partners or owners with a 5 percent or more controlling interest.
• Disclosure Requirements: Medicaid providers are required to disclose information regarding:
  – the identity of all individuals and entities with an ownership or control interest of 5 percent or greater in the provider including information about the provider’s agents and managing employees in compliance with 42 CFR 455.104
  – certain business transactions between the provider and subcontractors/wholly owned suppliers in compliance with 42 CFR 455.105
  – the identity of any individual or entity with an ownership or control interest in the provider or disclosing entity, or who is an agent or managing employee of the provider group or entity that has ever been convicted of any crime related to that person’s involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children’s Health Insurance Program) of the Social Security Act since the inception of those programs in compliance with 42 CFR 455.106

Remember—Magellan Complete Care has a non-retaliation policy.

Magellan Complete Care will not retaliate against you or any of its employees, agents and contractors for reporting suspected cases of fraud, waste, or abuse to us, the federal government, state government, or any other regulatory agency with oversight authority. Federal and state law also prohibits Magellan Complete Care from discriminating against an employee in the terms or conditions of their employment because the employee initiated or otherwise assisted in a false claims action.

Magellan Complete Care also is prohibited from discriminating against agents and contractors because the agent or contractor initiated or otherwise assisted in a false claims action.

Magellan’s responsibility is to implement and regularly conduct fraud, waste and abuse prevention activities that include:
• Extensively monitoring and auditing provider utilization and claims to detect fraud, waste and abuse
• Actively investigating and pursuing fraud and abuse and other alleged illegal, unethical or unprofessional conduct
• Reporting suspected fraud, waste and abuse and related data to federal and state agencies, in compliance with applicable federal and state regulations and contractual obligations
• Cooperating with law enforcement authorities in the prosecution of healthcare and insurance fraud cases
• Verifying eligibility for members and providers
• Utilizing internal controls to help ensure payments are not issued to providers who are excluded or sanctioned under Medicare/ Medicaid and other federally funded healthcare programs
• Training employees annually on Magellan’s Corporate Compliance Handbook
• Making the Magellan Complete Care Provider Handbook available to network providers.
Cultural Competency Plan

All Magellan Complete Care members should be treated with dignity and respect by the provider and their staff. Magellan providers are prohibited from discriminating against different types of patients based on race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, source of payment or health status.

Magellan Complete Care has implemented a comprehensive cultural competency plan to improve our members’ health outcomes, quality of care, and to reduce disparities in racial and ethnic healthcare. The plan follows The National Standards on Culturally and Linguistically Appropriate Services (CLAS) to educate our employees, members, and providers on the importance of communication in a preferred language and respect for cultural health beliefs. These standards are also used to inform members about their rights to receive effective, understandable, and respectful care that is provided in a manner in which their cultural health beliefs are in their preferred language. To receive a full copy, at no cost, of the Magellan Complete Care Cultural Competency Plan, please visit our website MagellanCompleteCareofFL.com or send your request in writing to:

Magellan Complete Care
Attn: Customer Service
PO Box 524083
Miami, FL 33152

To receive training for you and/or your staff, please call Provider Services.

Magellan Complete Care provides educational and informational materials about our plan in English and Spanish and in other languages on request. Customer Service can provide written materials such as large print, audio tape or Braille (for the blind) upon request.

Interpreter services for all languages including sign language are provided free for our members. Magellan Complete Care has a telephone language line available 24 hours a day, seven days a week.

We are also able to provide on-site translators through Global Interpreting. Call Customer Service for more information and to schedule.

Magellan Complete Care provides community-based medical linkage that supports racial and ethnic minorities and the disabled to ensure community resources are accessible to members’ with special needs.

The provider has the following responsibilities related to Cultural Competency:

- **Non-Discrimination:** The provider agrees to practice in their profession ethically and legally, provide all services in a culturally competent manner, accommodate those with disabilities and not discriminate against anyone based on their health status.
- **Interpretive Services:** The provider agrees to contact Magellan Complete Care for assistance with interpretive services when no one in their medical office is able to communicate with a member in their primary language.
- **Objection on Religious Grounds:** The provider agrees to inform Magellan Complete Care if he/she objects to the provision of any counseling, treatments or referral services on religious grounds.
Member Rights and Responsibilities

Key provider responsibilities related to Member Rights and Responsibilities are:

- **Treatment of Member**: The provider agrees to treat all members with respect and dignity, to provide them with appropriate privacy and to treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release in accordance with HIPAA and applicable state laws.

- **Disclosure of Information to Member**: The provider agrees to provide to the members complete information concerning their diagnosis, evaluation, treatment and prognosis, and to give members the opportunity to participate in decisions involving their healthcare, regardless of whether the member has completed an advance directive, except when contraindicated for medical reasons.

- **Florida Bill of Rights**: Magellan Complete Care has adopted the Florida member’s Bill of Rights and Responsibilities. All providers should have a copy of this document in their office.

**Members have the right to:**

- Be treated with courtesy and respect
- Protection of privacy
- Receive a prompt response to questions and requests
- Know who is providing your medical services and care
- Know what services are available. This includes if you need an interpreter because you don’t speak English
- Know what rules and regulations apply to your conduct
- Be given the truth about your health status
- Refuse any treatment, except as otherwise provided by law
- Participate in decisions about their health care.
- Be given full information and counseling on the availability of known financial resources for your care
- Know whether the healthcare provider or facility accepts the Magellan’s contract rates
- Receive, prior to treatment, a reasonable estimate of cost
- Receive a copy of an itemized bill. If you want to have the charges explained, the provider must do so.
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment
- Know if medical treatment is for purpose of experimental research. If it is, then you can refuse or accept the services
- Express complaints regarding any violation of your rights
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee’s condition and ability to understand
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of their medical records and request that they be amended or corrected
- Be furnished healthcare services in accordance with federal and state regulations
A member is responsible for:

- Giving the provider accurate information about their past and present health status
- Reporting unexpected changes in their health status
- Telling the provider they understand what is expected of them
- Following the treatment plan recommended by the provider
- Keeping doctor appointments
- If they can’t keep the appointment, notify the provider they can’t come
- Knowing what will happen to them if they ignore the provider’s treatment plan
- Making sure financial responsibilities are met
- Following the provider’s conduct rules and regulations

The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat the enrollee.

Magellan Complete Care is in charge of making sure that they get the amounts owed by all members. This is decided by the Florida Department of Children and Families (DCF). Magellan Complete Care has rules and processes in place to make sure that members are charged and pay the amounts that they owe. Some members may not owe fees. This may happen because of their low pay. It can also happen because of the means that were used to decide on the amount owed.

Patient Responsibility to Residential Providers

Magellan Complete Care can give the task of gathering its members’ fees to the residential providers and pay the residential providers a net of the fee amount. If Magellan Complete Care lets the residential provider collect the fees, the residential provider contract will give full details of both groups’ duties on getting the members’ fees. Magellan Complete Care can either gather the members’ fees from all of its providers or give the collection to all of its residential providers.
Provider Complaints

The Managed Care Plan’s process for provider complaints concerning claims issues will be in accordance with s. 641.3155, F.S.

For provider complaints concerning non-claims issues, the Managed Care Plan will:

- Allow providers forty-five (45) days to file a written complaint for issues that are not about claims;
- Within three (3) business days of receipt of a complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution;
- Document why a complaint is unresolved after fifteen (15) days of receipt and provide written notice of the status to the provider every fifteen (15) days thereafter; and
- Resolve all complaints within ninety (90) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

There are three types of provider complaints with different filing requirements:

**Policy-Related Complaints**

All complaints disputing the policies, procedures or any aspect of the administrative functions of Magellan Complete Care can be oral or written. The complaint must be filed no later than 45 calendar days from the date the provider becomes aware of the issue generating the complaint. Provider policy-related complaints may be filed in writing.

Magellan Complete Care
Attn: Complaint Coordinator
PO Box 524083
Miami, FL 33152
FLMCCQI@MagellanCompleteCare.com

**Utilization Management-Related Complaints**

Providers have 45 days from the date on the notice of the original utilization management decision to file a complaint regarding the utilization management decision process.

However, in order to submit a provider dispute/appeal regarding an adverse benefit determination, a provider must comply with the adverse benefit determination which states that for a provider to dispute, the dispute must be filed within 30 days from the date that is on the notice. Members have 60 days to appeal. These timeframes should not be confused and for the provider dispute/appeal to be considered timely, the required summary and the medical records must be received by the health plan on the 30th day.

The summary must be one of the following:

- A detailed cover letter to include the items specified in the Provider Appeals form. The cover letter must identify why the medical records were sent as well as a clinical summary of the provider’s rebuttal with references to national criteria such as; Interqual and/or Milliman—or
- A complete and detailed Provider Appeals form (additional pages can be attached).

The decision on the dispute will be based entirely on the submitted medical records—Magellan Complete Care will not request additional records or information to evaluate the complaint.
There is no second level consideration for cases that are denied for untimely filing. If the provider feels they have filed their case within the appropriate time frame, they may submit proof. Acceptable proof of timely filing must only be in the form of a registered postal receipt signed by a representative of Magellan, or similar receipt from other commercial delivery services. Magellan will respond to the provider’s request for review.

Magellan Complete Care  
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PO Box 524083  
Miami, FL 33152  
FLMCCQI@MagellanCompleteCare.com

**Claims-Related Disputes**

Providers have from the following timeframes to file a provider complaint or submit additional information or documentation.

- In network providers: 90 days
- Out of network providers: 365 days

Complaints filed after that time will be denied for untimely filing.

There is no second level consideration for cases denied for untimely filing. If the provider feels they have filed their case within the appropriate time frame, they may submit proof. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of Magellan, or similar receipt from other commercial delivery services. Magellan will respond to the provider’s request for review.

Examples of claims disputes include but are not limited to:

- Paid incorrectly—under or over paid
- Missing mandatory fields
- Diagnosis is not billable with CPT code

Claims denials for no authorization on file or clinical department denials are processed in accordance with the retrospective review or provider dispute/appeals process.

For denials involving the denial code of “max 45 inpatient benefit limit reached” or “medical records request for PPC” (Provider Preventable Condition); these are handled and processed through the appeals department and no timeframes are associated with these submissions.

All complaints concerning claims payment issues must be filed in writing.

If the provider complaint regarding claims payment requires review for medical necessity as in a retrospective review or provider dispute/appeal, all medical records and supporting documentation necessary for the review should be sent in accordance with the timeframes associated with same. The decision on the complaint, where there is a medical necessity determination made, will be based entirely on the submitted medical records—Magellan Complete Care will not request additional records or information to evaluate the complaint.

Magellan Complete Care  
Attn: Complaint Coordinator  
PO Box 524083  
Miami, FL 33152  
FLMCCQI@MagellanCompleteCare.com

A provider may also contact Provider Services at 800-327-8613 where dedicated staff is available to answer questions, assist in filing a provider complaint and resolve any issues. They are available anytime between 8 a.m. to 7 p.m. Eastern Time, Monday through Friday, excluding State Holidays, or leave a message after hours that will be returned on the next business day.
Provider Complaint Process

Magellan Complete Care will review the complaint for medical necessity and conformity to Plan guidelines and contractual obligations. During this time, Magellan Complete Care may request additional information from the provider in order to complete a review of the complaint. At the conclusion of the review, the provider will receive a written decision with an explanation for the decision.

All provider complaints will be thoroughly investigated using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying Magellan Complete Care written policies and procedures. Magellan Complete Care will also ensure that the appropriate decision makers with the authority to implement corrective action are involved in the provider complaint process. Magellan Complete Care shall provide a written notice of the outcome of the review to the provider.

External Claims Dispute Process

Statewide Provider and Health Plan Claim Dispute Resolution Program

The Agency for Health Care Administration (AHCA) has contracted with MAXIMUS, an independent dispute resolution organization, to provide assistance to health care providers and health plans for resolving claim disputes. Claim disputes must have been submitted by the provider or the health plan and they must have been denied in full or in part, or were presumed to have been underpaid or overpaid. Application forms and instructions on how to file claims are available from MAXIMUS directly at 1-866-763-6395. Ask for Florida Provider Appeals Process. Please contact Maximus to determine if your claims dispute is eligible for review.

Magellan Complete Care is not responsible for payment for medical records generated as a result of a provider complaint or for records requested for the investigation of critical incidents, utilization review or quality of care reviews. Any invoices received by Magellan Complete Care for such charges will be redirected to the provider. Complaints received without the necessary documentation will be denied for lack of information and the provider will be notified.
Member Grievance and Appeals

**Complaint**: A member complaint is any expression of dissatisfaction by a member and must be resolved by Magellan Complete Care within one business day. If not, this complaint will become a grievance.

**Grievance**: A grievance is a formal complaint from a member or designee on their behalf about a provider or service. This must be resolved by Magellan Complete Care within 90 days. The member will receive an adverse benefit determination from Magellan Complete Care.

**Appeal**: An appeal is a formal request from a member, their authorized representative, or their legal representative of the estate about a service that is denied. This is not for provider’s acting on their own behalf to resolve adverse benefit determinations made by Utilization Management.

Those acting on behalf of the member must provide the member’s (written) consent except when the member is in acute inpatient facility. An appeal can be filed orally or in writing. If the appeal is oral, it must be followed up in writing within 10 days. Member appeals must be made within 60 days from the date on the adverse benefit determination from Magellan and will be resolved by Magellan Complete Care within 30 days of receipt for standard appeals. The member will receive an adverse benefit determination from Magellan Complete Care.

If the member (or their authorized representative) needs help with filing a grievance or appeal, please call Grievance and Appeals toll free at 800-327-8613. Our Grievance and Appeals department is available from 8:00 am – 7:00 pm Monday – Friday.

Please mail the member’s grievance or appeal to:
Magellan Complete Care
Attn: Complaint Coordinator
PO Box 524083
Miami, FL 33152

**Authorized Representative**: An individual who has the legal authority to make decisions on behalf of an enrollee or potential enrollee in matters related to the Managed Care Plan.

**Expedited Appeal**: If a member’s health is in danger and an expedited review is required, please let Magellan Complete Care know it’s urgent. Magellan Complete Care will make a decision within 72 hours of receipt.

During the process, the member can continue to receive care at no cost. However, if the final decision is not in their favor, they may have to pay for the care.

If a member (or their provider on their behalf) needs help with filing an expedited grievance or appeal, please call Grievance and Appeals toll free at 800-327-8613. Please remember to tell Magellan Complete Care it is urgent. Our Grievance and Appeals department is available from 8:00 am – 7:00 pm Monday – Friday.

Please mail your grievance or appeal to:
Magellan Complete Care
Attn: Complaint Coordinator
PO Box 524083
Miami, FL 33152
Medicaid Fair Hearing

If a member or their authorized representative does not agree with Magellan’s decision regarding their grievance or appeal, they or their authorized representative can request a Medicaid Fair Hearing (within 120 days from the date on the plan appeal resolution notice).

Per Florida Administrative Code 65-2.045(3) Hearings Request: A Request for Hearing may be made by the applicant/recipient or someone in his/her behalf. However, if the appeal is filed by someone other than the applicant/recipient, attorney, legal guardian, spouse, next of kin, the grantee relative in cash assistance, or a person allowed by the Department as an authorized representative to participate in the eligibility determination, the person making the appeal must have written authorization of the applicant/recipient.

To request a fair hearing, notification should be mailed to the address below or the member should contact the agency directly:

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

Subscriber Assistance Program (within 1-year from the date of the final determination notice)

The state’s Subscriber Assistance Program (SAP) is an external conflict resolution program available to Medicaid participants that provides an additional level of appeal if the Managed Care Plan’s process does not resolve the conflict.

The member can request review from the Subscriber Assistance Program within one year after the date of the member’s initial appeal. To request review from the Subscriber Assistance Program, notification should be mailed to the address below or the member should contact the agency directly:

Agency for Health Care Administration
Subscriber Assistance Program
Building 3, MS #45
2727 Mahan Drive
Tallahassee, Florida 32308
850-412-4502
888-419-3456 (toll-free)

If the member (or their provider on their behalf) requests a Medicaid Fair Hearing, he/she cannot file for the Subscriber Assistance Program.

During the process, members may, if they choose, continue to receive care at no cost. However, if the final decision is not in their favor, they may have to pay for the care.
Medical Management

Medical Necessity Standards
Magellan’s Medical Necessity Criteria (MNC), which is based on current scientific evidence and clinical consensus, are used in making medical necessity determinations. We review the criteria annually, taking into consideration current scientific evidence and provider feedback, and revise them as needed. We also align these criteria with the Agency for Healthcare Administration’s medical necessity standards and practice protocols. The criteria are made available to any interested party on the MCCofFL.com website or by hard copy upon request by calling Member Services at 1-800-327-8613.

Services that include medical or allied care, goods, or services furnished or ordered must be provided under 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 members, the member’s caretaker, or the provider.

Medically necessary or medical necessity for those services furnished in a hospital on an inpatient basis must be (1) consistent with the provisions of appropriate medical care and (2) 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 or allied goods or services does not, in and of itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

Treatment Adherence
Magellan Complete Care of Florida has medication and treatment adherence programs available to help ensure that members continue in care and obtain maximum benefit from their care. Through interdisciplinary meetings and treatment planning, we are able to work in collaboration and coordination with our providers to establish and monitor treatment plans that are targeted and tailored to each member. Through our health guides, peer support specialist and care managers we are able to outreach to members, provide them with the support they need to address barriers influencing their ability to obtain care and also aid in transitions of care that can be difficult to navigate. At each step we rely on the collaboration with our network providers to develop treatment adherence strategies that work for our members.
Mental Health and Substance Abuse Assessments

Magellan Complete Care’s plan preference is for providers to use the following assessments:

- CAGE-AID for substance abuse
- AUDIT (Alcohol Use Disorders Identification Test)
- DAST-10 (drug Abuse Screen Test)
- PHQ 9 for depression
- Mental Health Screening Form III

Magellan Complete Care recognizes that there are additional tools for the assessment of substance abuse and mental health and will support the use of other peer reviewed and validated instruments.

Continuity of Care

Magellan Complete Care will allow members in active treatment to continue to receive care from their current provider for the first 60 calendar days with our plan. After the 60 days pass, Magellan Complete Care will work closely with the member and the non-par provider to determine continuation of care by the non-par provider. Magellan Complete Care will only authorize treatment in special cases.

Prior Authorization

Prior authorization must be requested for some services through Magellan’s Health Services department, which is available 24 hours a day, 7 days a week. Providers are expected to submit a pre-service authorization request to the Plan prior to providing the service or care. For services that require an authorization, claims submitted for services provided without prior authorization will be denied. Please call us or use the electronic request process at MagellanCompleteCareofFL.com. You may also utilize the prior authorization forms found on MagellanCompleteCareofFL.com.

Members may seek behavioral health services without the referral of the Primary Care Physician. Magellan Complete Care Integrated Case Managers and Health Guides will work collaboratively in coordinating care with members and their Primary Care Physicians in order to ensure that all care and services are coordinated and integrated into the member’s comprehensive treatment plan.

Services that require a prior authorization that are rendered without authorization will be denied for payment.

Magellan Complete Care may allow a standing authorization to be approved for members with chronic or disabling conditions. Providers should specifically request these authorizations when working with Magellan Complete Care case and disease managers on care plans for their patients.

Decisions on routine prior authorizations will be rendered within 14 calendar days. Decisions on expedited prior authorization requests will be rendered within 3 business days, if Magellan determines that the request qualifies for expedited consideration. The provider will be notified if the request will not be considered as an expedited request.
Decisions for approved services are based only on appropriateness of care and service and existence of coverage. Utilization Management staff and Medical Directors are not financially or otherwise compensated to encourage underutilization and/or denials.

The following services do not require prior authorization from Magellan. This list is subject to change. A complete list can be found at www.MagellanCompleteCareofFL.com. Notifications of changes will also be sent via provider bulletin.

- Emergency services
- Post stabilization services or other post stabilization care as identified under 42 CFR 422.113©
- Some chiropractic services at a participating provider
- Annual eye exam at a participating Optometrist
- Some podiatric services at a participating provider
- Dermatology services up to 5-times per year with no referral at a participating provider
- Family planning services may be obtained from any Medicaid provider without prior authorization
- Annual well woman exam at a participating provider and follow-up care as needed
- Diagnosis and treatment of sexually transmitted disease when provided at the Community Health Department
- Routine outpatient behavioral health services such as evaluations, medication management, individual and/or family therapy

If members receive care from out-of-network providers without prior authorization, Magellan Complete Care will not pay for this care. PCPs should contact Magellan Complete Care if they wish to request an exceptional referral for the member to see an out-of-network provider. If an out-of-network provider provides emergency care, the service will be paid for.
**Covered Services**

Limits and prior authorizations exist for some of these services and these benefits are subject to change. Please contact us to confirm benefit information. Visit our website at MCCofFL.com for more details.

**Service:**
- Advanced Registered Nurse Practitioner Services
- Ambulatory Surgical Center Services
- Birth Center Services
- Child Health Check-Up Services
- Chiropractic Services
- Community Behavioral Health Services
- County Health Department Services
- Crisis Help
- Dental Services
- Durable Medical Equipment / Medical Supplies
- Dialysis Services
- Emergency Room Services
- Family Planning Services
- Federally Qualified Health Center Services
- Hearing Services
- Home Healthcare Services and Private Duty Nursing Care
- Hospice
- Hospital Services—Inpatient
- Hospital Services—Outpatient
- Immunizations—Childhood
- Independent Laboratory Services
- Licensed Midwife Services
- Mental Health Counseling
- Nursing Facility Services
- OB Services
- Optometric Services
- Physician Services
- Physician Assistant Services
- Podiatry Services
- Portable X-Ray Services
- Prescribed Drugs (including Behavioral Health)
- Preventative Services—e.g. CHCUP, Well Woman Exams, Mammograms
- Primary Care Case Management Services
- Radiology Services
- Rural Health Clinic Services
- Substance Abuse Support
- Targeted Case Management
- Therapeutic Group Care (TGC)
- Therapy Services (Occupational, Physical, Respiratory, and Speech) Eligible recipients include members under the age of 21. The therapy services program also provides limited services to recipients age 21 and older specifically SLP services pertaining to the provision of augmentative and alternative communication systems and PT and OT services pertaining to wheelchair evaluations and fittings.
- Transplant Services
- Transportation Services
- Vision Services
## Magellan Complete Care Expanded Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
<th>Authorization required?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental—expanded for adults</strong></td>
<td>• Maximum $1500 benefit</td>
<td>Yes— for treatment of periodontal disease</td>
</tr>
<tr>
<td></td>
<td>• Preventive services—one cleaning and oral exam every 6 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• One x-ray per year</td>
<td></td>
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<tr>
<td></td>
<td>• One fluoride treatment per year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Treatment for periodontal disease</td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Visits—enhanced for non-pregnant adults</strong></td>
<td>• Can exceed 3 visits per day when medically necessary</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Intensive Outpatient Therapy for Substance Abuse</strong></td>
<td>• No limits when medically necessary</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Nutritional Counseling</strong></td>
<td>• Up to 15 visits per year</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>OB Visits</strong></td>
<td>• 10-14 visits for routine pregnancy care</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>• No limit for high risk pregnancy care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 1 postpartum home visit</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Hospital Services</strong></td>
<td>• $500 per year plus the Medicaid benefit of $1500 based on medical necessity and in lieu of hospital admission</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Over the Counter Medication/Supplies</strong></td>
<td>• Certain over the counter medications and supplies</td>
<td>Requires prescription</td>
</tr>
<tr>
<td></td>
<td>• See drug and supply list on our website</td>
<td></td>
</tr>
<tr>
<td><strong>Post discharge meals</strong></td>
<td>• Post discharge from inpatient admission; Up to 48 hours for member and up to 3 family members; requires 48 hours notice by member</td>
<td>Yes</td>
</tr>
<tr>
<td>Service</td>
<td>Benefit</td>
<td>Authorization required?</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Primary Care Visits—enhanced for non-pregnant adults</td>
<td>• One per day &lt;br&gt; • Not limited to 2 per month</td>
<td>No</td>
</tr>
<tr>
<td>Vaccines—adult</td>
<td>• Pneumonia and Shingles shots one per lifetime &lt;br&gt; • Flu shot one per year for members 19 and over</td>
<td>No</td>
</tr>
<tr>
<td>Vision Services</td>
<td>• Routine eye exam and glasses once every 12 months &lt;br&gt; • Additional exams and glasses when medically necessary &lt;br&gt; • For Specialty Fits (new wearers, historic, RGP, multi-focal, etc.), the enrollee must pay for any charges over $50, less a 20 percent discount</td>
<td>Yes—for services beyond the annual benefit</td>
</tr>
<tr>
<td>Co-pays</td>
<td>• Waived &lt;br&gt; • Providers are not permitted to charge co-pays for any covered service for Magellan Complete Care members.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## Additional Notes for Covered Services

<table>
<thead>
<tr>
<th>Service</th>
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<th>Authorization required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental—adult</td>
<td>All dental treatment or surgery is considered necessary when the dental condition is likely to result in a medical condition if left untreated.</td>
<td>Yes</td>
</tr>
<tr>
<td>Diabetes Care</td>
<td>We cover all needed equipment, supplies, and services to treat diabetes, including self-management training and educational services if ordered by your doctor.</td>
<td>No</td>
</tr>
<tr>
<td>Family Planning Services</td>
<td>May get services from any participating Medicaid provider</td>
<td>No</td>
</tr>
</tbody>
</table>
| Inpatient Hospital Services | Members over the age of 21 are limited to 45 days per Medicaid fiscal year  
There is no limit for members under the age of 21 or for emergency care and pregnant adults.                              | Yes                    |
<p>| Nursing Facility Services | Magellan Complete Care will furnish nursing facility services to members under the age of eighteen (18) years. For nursing facility contracts for services to members under the age of eighteen (18) years, the nursing facility provider must notify the Department of Children and Families of the admission to and discharge from a nursing facility. | Yes                    |
| Nursing Facility Admissions | Nursing facility providers must submit a completed DCF #2506A Form (Client Referral/Change) to the Department of Children and Families (DCF) within ten (10) business days of the admission to a nursing facility of an MMA enrollee under the age of eighteen (18) years. | Yes                    |
| Nursing Facility Discharges | The nursing facility providers must submit a completed DCF #2506 Form (Client Discharge/Change Notice) to the Department of Children and Families (DCF) within ten (10) business days of the discharge from a nursing facility of an member under the age of eighteen (18) years. | Yes                    |
| Outpatient Services      | There is no limit for members under the age of 21.                                                                                                                                                     | Yes                    |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
<th>Authorization required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services</td>
<td>May be given by individuals who are not licensed physicians, including nurse practitioners and physician assistants, when under the direction of your PCP. Limited to one visit per day unless for an emergency, one new patient evaluation, one long term care facility visit per month.</td>
<td>No</td>
</tr>
<tr>
<td>Therapeutic Group Care</td>
<td>Therapeutic group care services or specialized therapeutic group care are community-based, psychiatric residential treatment services designed for recipients under the age of 21 years with moderate to severe emotional disturbances. They are provided in a licensed residential group home setting serving no more than 12 recipients. Providers must comply with the regulations and requirements listed in the Specialized Therapeutic Services Coverage and Limitations Handbook. A copy of the authorization form for this service can be found in our website under the provider section: “Authorizations”</td>
<td>Yes</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>A female member, without approval from her PCP, may visit a contracted obstetrician/gynecologist (OB/GYN) for one annual visit and for medically necessary follow up care as a result of that visit.</td>
<td>No</td>
</tr>
</tbody>
</table>
## Subcontractors and Inter-company Partners with Magellan Complete Care

Magellan Complete Care works with the following partners and sub-contractors to coordinate and manage the following covered services below:

<table>
<thead>
<tr>
<th>Contracted Entity</th>
<th>Services Provided</th>
<th>Entity Type</th>
<th>Authorization required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magellan Rx Management</td>
<td>Specialty Pharmacy</td>
<td>Inter-company partner</td>
<td>Yes</td>
</tr>
<tr>
<td>NIA</td>
<td>Advanced Radiology</td>
<td>Inter-company partner</td>
<td>Yes</td>
</tr>
<tr>
<td>Magellan Rx Management</td>
<td>Pharmacy Benefit Management</td>
<td>Inter-company partner</td>
<td>Yes</td>
</tr>
<tr>
<td>DentaQuest</td>
<td>Dental, routine and preventative</td>
<td>Subcontractor with UM delegation</td>
<td>Yes</td>
</tr>
<tr>
<td>Florida Eye Care</td>
<td>Vision, routine and preventative</td>
<td>Subcontractor</td>
<td>Yes</td>
</tr>
<tr>
<td>Premiere Eye</td>
<td>Vision, routine and preventative</td>
<td>Subcontractor with UM delegation</td>
<td>Yes</td>
</tr>
<tr>
<td>Veyo</td>
<td>Transportation, non-emergency</td>
<td>Subcontractor</td>
<td>Advanced reservations required</td>
</tr>
<tr>
<td>Coastal Care Services</td>
<td>Home Health / Home Infusion Therapy / DME</td>
<td>Subcontractor</td>
<td>Yes</td>
</tr>
<tr>
<td>HearUSA</td>
<td>Audiology, hearing evaluations. Hearing aids through Magellan Complete Care</td>
<td>Subcontractor</td>
<td>No</td>
</tr>
</tbody>
</table>
Waived Copayments & Fees

In accordance with the American Recovery and Reinvestment Act of 2009; Magellan Complete Care will not impose enrollment fees, premiums, or similar charges on Indians served by an Indian health care provider, Indian Health Service, an Indian Tribe, Tribal Organization, an Urban Indian Organization or through referral under contract health services.

Second Medical Opinion

Members have the right to a second medical opinion. If the organization cannot provide for a second opinion from an in-network provider, arrangements can be made for a second opinion outside the network. Please contact our Health Services department at 1-800-327-8613 for a prior authorization request.

Emergency Services

Providers are required to ensure adequate accessibility for healthcare twenty-four (24) hours per day, seven days per week. In cases of an emergency, the member should go to the closest emergency room or any other emergency setting. An emergency is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the health of a patient, including a pregnant woman or a fetus, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. In addition, an emergency, with respect to a pregnant woman, is also defined as situations where there is inadequate time to effect safe transfer to another hospital prior to delivery, a transfer may pose a threat to the health and safety of the patient or fetus, or there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Members are encouraged to contact their PCP as soon as possible when they are in a hospital, or have received emergency care.

The facility is required to notify Magellan Complete Care within 24 hours when a member accesses the facility.

If the emergency room doctor treating the member states to the member that the visit is not an emergency, the member will be given the choice to stay and get medical treatment or follow up with their primary care physician. If the member decides to stay and receive treatment and it has been determined that the care is not deemed medically necessary, the services will be denied and will not be a covered benefit.

If the member is treated for an emergency, and the treating doctor recommends treatment after the member is stabilized, the member will be encouraged to call their Magellan Complete Care PCP.

Magellan Complete Care does not deny claims for emergency services and care received at a Hospital due to lack of parental consent. In addition, Magellan Complete Care does not deny claims for treatment obtained when a primary care physician or a representative of Magellan Complete Care instructs the member to seek Emergency Services and Care.
Magellan or the provider affiliated with the plan will not:

- Require prior authorization for a member to receive pre-hospital transport or treatment or for emergency services and care
- Specify or imply that emergency services and care are covered by Magellan only if secured within a certain period of time
- Use terms such as “life threatening” or “bona fide” to qualify the kind of emergency that is covered
- Deny payment based on a failure by the member or the hospital to notify Magellan before, or within a certain period of time after, emergency services and care were given

Magellan covers any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until such time as Magellan can safely transport the member to a participating facility. Magellan may transfer the member, in accordance with state and federal law, to a participating hospital that has the service capability to treat the member’s emergency medical condition. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.

Magellan will not deny claims for the provision of emergency services and care submitted by a nonparticipating provider solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds 365 days.

Emergency Ambulance Services

Magellan reimburses for emergency transportation (ALS or BLS) by ambulance, whether ground or air. Emergency transportation does not require prior authorization.

Codes for Emergency Ambulance Services:
- A0429 Ambulance Service, Basic Life Support
- A0427 Ambulance Service, Advanced Life Support
- A0433 Advanced Life Support, Level 2 (ALS2)
- A0434 Specialty Care Transport (SCT)
- A0999 Negotiated Transportation Services for Mileage

Mileage is not reimbursed unless the member is transported outside of the county. If the recipient is transported out of the county in which the recipient was picked up, provider will be reimbursed $3.00 per mile plus the base rate. This rate begins at the point of pickup.

OB Ultrasound Authorizations

Magellan Complete Care does not require prior authorization for OB Services. This includes OB Ultrasound procedures, Monitoring of OB Ultrasounds, Biophysical Profiles, and the Vessel Doppler Ultrasounds

Out of Area Emergency Services

If the member is away from home and has an emergency, they are instructed to go to the nearest emergency room, any emergency setting, of their choice. In such situations, the member should call their PCP as soon as possible.
Emergency Room Prudent Layperson Facility Reviews

Magellan Complete Care Prudent Layperson reviews emergency services claims to determine whether a member presented to the emergency room with an emergency medical condition.

As per the State of Florida Agency for Health Care Administration Statewide Medicaid Managed Care Contract language:

**Emergency Medical Condition**—(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in any of the following: (1) serious jeopardy to the health of a patient, including a pregnant woman or fetus; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman: (1) that there is inadequate time to effect safe transfer to another hospital prior to delivery; (2) that a transfer may pose a threat to the health and safety of the patient or fetus; (3) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes. (See s. 395.002, F.S.)

For services rendered in an emergency room for treatment of conditions that do not meet the prudent layperson standard as an emergency medical condition, Magellan Complete Care will limit reimbursement to a triage fee (one revenue code at the outpatient per diem rate). There are two exceptions to this requirement:

- The Primary Medical Physician referred the enrollee for treatment.
- The enrollee called the Magellan Complete Care 24/7 Nurse Line and received prior authorization to go to the emergency room.

Magellan Complete Care has identified a list of diagnosis codes that qualify to autopay and would not be subject to review; as these codes clearly demonstrate that an emergency condition existed. If the primary diagnosis codes matches a diagnosis code on the autopay list, the claim will be paid following the standard outpatient reimbursement guidelines. If the primary diagnosis code does not match a diagnosis code on the list, medical records will be reviewed by a Prudent Layperson to determine if the member is presented with an emergency condition.

At a minimum, the facility will receive reimbursement for the triage fee to cover screening services. For facility charges billed on UB-04:

- If the member did not present with an emergency condition, bill the revenue code 451 for reimbursement of the triage fee (one revenue code at the outpatient facility per diem rate).
- If the facility bills the revenue code 450 and the primary diagnosis does not hit the autopay list, we will reimburse one revenue line at the outpatient per diem rate if:
  - A prudent layperson review determines the service was not an emergency
  - And the non-emergency decision is upheld by the Magellan Complete Care Medical Director.

An Explanation of Payment (EOP) will indicate the triage rate, including an explanation code with the option to request a timely reconsideration of the claim in writing within 35 calendar days by submission of medical records and other clinical rational that supports overturning the triage rate.

Medical records should be mailed to:

Magellan Complete Care
PO Box 2097
Maryland Heights, MO 63043
Child Health Check-Up/
Vaccines

Magellan promotes wellness visits for all their members. Child Health Check-Ups are an integral part of our wellness program. Magellan Complete Care will reach out to the parents of newly enrolled infants and children to determine the date of the last CHCUP visit and also to parents of existing members with a gap in care to schedule a PCP visit. These visits include comprehensive health and developmental history (including assessment of past medical history, developmental history and behavioral health status) for eligible children birth through 20 years old:

- Comprehensive unclothed physical examination;
- Developmental assessment;
- Nutritional assessment;
- Appropriate immunizations according to the appropriate recommended childhood immunization schedule for the United States;
- Laboratory testing (including blood lead testing);
- Health education (including anticipatory guidance);
- Dental screening (including a direct referral to a dentist for members beginning at age three or earlier as indicated) including fluoride treatment;
- Vision screening, including objective testing as required;
- Hearing screening, including objective testing as required;
- Diagnosis and treatment; and referral and follow-up as appropriate.

Magellan’s members under the age of 21, should have their child health check-up visits at:

- Birth
- 2—4 days for newborns discharged in less than 48 hours after delivery
- 1-month
- 2-months
- 4-months
- 6-months
- 9-months
- 12-months
- 15-months
- 18-months
- 24-months
- 30-months
- Once every year for ages 3—20

Additional child health check-up visits can be requested at other times if the guardian feels it is needed. Magellan Complete Care provides transportation to and from visits as needed through Veyo.

In addition, the provider has responsibilities with regard to the administration of vaccines:

- **Participation in Immunization Registry**: The PCP is encouraged to participate with Florida’s Immunization Registry (SHOTS).
- **Tracking and Administration of Vaccines**: The PCP agrees to maintain vaccines safely, in adequate supply, and in accordance with specific guidelines, to provide member immunizations according to professional standards and to maintain up-to-date member immunization records.
- **Vaccines for Children**: The PCP for Medicaid members must use their Vaccines for Children Program (VFC) supply. The VFC program covers children from birth to 18 years of age. Florida Medicaid requires vaccines for Medicaid children from birth through 20 years of age. Members 19 through 20 years of age should receive their vaccinations from their PCP and will be reimbursed at the applicable Medicaid rate.
Blood Lead Screening: Providers are also required to screen all enrolled children for lead poisoning at ages 12 months and 24 months. In addition, children between the ages of 12 months and 72 months must receive a screening blood lead test if there is no record of a previous test. Magellan Complete Care provides additional diagnostic and treatment services determined to be medically necessary to a child/adolescent diagnosed with an elevated blood lead level. Paper filter tests are recommended as part of the lead screening requirement, but not required. Magellan Complete Care will provide case management follow-up services for children with abnormal blood lead screenings.

For an authorization of a medically necessary service that is needed for members under the age of twenty-one (21) years in circumstances where:

The service is not listed in the service-specific Medicaid Coverage and Limitations Handbook, fee schedule, 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; the medically necessary service will be reviewed by a Medical Director. Both member and the requesting provider will be notified of the determination once the request has been approved and authorized.

Telemedicine

Magellan Complete Care supports the use of telemedicine. Providers interested in providing telemedicine services should contact their provider contracting rep to add the appropriate addenda to their contract. The contract documents will spell out requirements and rates for telehealth and training will be scheduled. At a minimum, the requirements for providers participating in Magellan’s telemedicine program include:

- Interactive and real-time synchronized multimedia (audio and video) transmission. Remote camera control is preferred. The provider must have a dedicated secure line and utilize an acceptable method of encryption.
- The originating site (location of the member) must have telehealth support staff able to assist the member with the technical equipment and connection. A protocol must be in place to access emergent or urgent clinical care if the designated telehealth support staff are not clinicians. The member site should be a room that provides privacy.
- Providers should have completed basic training on telehealth equipment, provide the same rights to confidentiality and security of clinical information as provided in face-to-face services, and must include in the member’s clinical record that the service was provided via telehealth.

All records must contain documentation to include the following items for services provided through telemedicine:

- A brief explanation of the use of telemedicine in each progress note
- Documentation of telemedicine equipment used for the particular covered services provided; and
• A signed statement from the enrollee or the enrollee’s authorized representative indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided.

If the provider has been approved by the Managed Care Plan to provide services through telemedicine, the provider is required to have protocols to prevent fraud and abuse. The provider must implement telemedicine fraud and abuse protocols that address:

• Authentication and authorization of users
• Authentication of the origin of the information
• The prevention of unauthorized access to the system or information
• System security, including the integrity of information that is collected, program integrity and system integrity; and
• Maintenance of documentation about system and information usage.

Community Referrals

Magellan Complete Care would like to assist you when the need for a referral for other services is identified. Magellan Complete Care has relationships and linkage agreements with community providers that offer services that complement the traditional benefits covered by the plan. These relationships allow us to collaborate with agencies that offer important ancillary services such as emergency shelter, housing, home-delivered meals, and emergency child care. We would like for you to call us if one of our members is in need of referrals of any kind. We would like to make sure we have the opportunity to be a partner to you. Magellan Complete Care counts on a large network of both providers and community contacts which we can access to meet our members’ needs. Additional information and referrals to service either covered through the plan or ancillary community services may be accessed by calling us at 1-800-327-8613.
Covered Pharmacy Services

Prescription drug benefits are managed through Magellan Complete Care and are administered by Magellan Complete Care’s prescription benefit manager, Magellan Pharmacy Solutions. Magellan Complete Care uses a Preferred Drug List (PDL). This is a list of prescription drugs approved by Magellan Complete Care for use by our members. All generic drugs and certain brand name drugs listed in the PDL are covered. Some drugs, even though they are listed on the PDL, may have special limitations such as quantity limits and age restrictions. Others may require the member to try and fail other preferred medications first. Non PDL drugs may be requested through the Prior Authorization process. Some drugs are excluded from the pharmacy benefits such as those for weight loss, infertility and cosmetic purposes. The PDL is available to providers on the Magellan Complete Care website at: MagellanCompleteCareofFL.com/fl-site/providers/preferred-drug-list/preferred-drug-list.

Pharmacy Policy

Magellan Complete Care’s pharmacy benefit provides access to a broad range of approved medications using a preferred drug list (PDL). The PDL does not:

- Require or prohibit the prescribing or dispensing of any medication;
- Substitute for the independent professional judgment of the physician or pharmacist; or
- Relieve the physician or pharmacist of any obligation to the patient or others.

Generic substitution may be mandatory when a generic equivalent is available. The mandatory generic substitution provision is waived for drugs that have a narrow therapeutic index such as warfarin, levothyroxine, digoxin and cyclosporine.

Prior Authorization

The PDL attempts to provide appropriate and cost effective drug therapy to all participants covered by the Magellan Complete Care pharmacy program. If a patient requires medication that does not appear on the PDL, the physician can make a request for a non-preferred medication. It is anticipated that such expectations will be rare and that PDL medications will be appropriate to treat the vast majority of medical conditions. In order for a member to receive coverage for a medication requiring prior authorization, the physician or pharmacist must submit a “Prior Authorization Request Form”. All relevant clinical information and previous drug history should be included and the form mailed, faxed or the request telephoned to:

Magellan Complete Care
c/o Magellan Pharmacy Solutions
11013 West Broad Street, Suite 500
Glen Allen, VA 23060
Phone: 1-800-327-8613
TTY: 1-800-424-1694
Fax: 1-800-424-7982

Prior Authorization form(s) can be found at: MagellanCompleteCareofFL.com/fl-site/providers/preferred-drug-list/pharmacy-prior-authorizations.

Providers are expected to submit a pre-service authorization request to the Plan prior to providing the service or care. For services that require an authorization, claims submitted for services provided without prior authorization will be denied.
Over-the-Counter Items

Over-the-counter items may be a covered benefit for some members. The Magellan Complete Care PDL covers several over-the-counter (OTC) medications and supplies. Over-the-counter items will not require a prescription and can be obtained at the store level. Magellan Complete Care will impose a limit of $25/month for OTC medications.

72-hour Emergency Supply Policy

All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour supply of non-PDL drugs (non-preferred drugs).

The following drug categories are not part of the Magellan Complete Care preferred drug list and are not covered by the 72-hour emergency supply policy:

- Anorectics: Drugs used for weight loss (unless prescribed for an indication other than obesity).
- Anti-Hemophilia Products (Billed as Fee-for-Service to Florida Medicaid).
- Cough and Cold Medications for members ages 21 and over.
- DESI ineffective drugs as designated by CMS
- Drugs used to treat infertility.
- Experimental/Investigational pharmaceuticals or products.
- Erectile dysfunction products prescribed to treat impotence.
- Hair growth restorers and other drugs used for cosmetic purposes.
- Immunizing agents (except for influenza vaccine).
- Injectable/Oral drugs administered by the provider in the office, in an outpatient clinic or and infusion center, or in a mental health center.
- Prostheses, appliances and devices (except products for Diabetics and products used for contraception).
- Injectable drugs or infusion therapy and supplies (except those listed in the PDL).
- Nutritional supplements.
- Oral vitamins and minerals (except those listed in the PDL).
- OTC drugs (except those listed in the PDL).
- Drugs covered under Medicare Part B and/or Medicare Part D.

Newly Approved Products

Newly Approved drug products will not normally be placed on the preferred drug list during their first six months on the market. During this period, access to these medications will be considered through the PA review process.
Care and Disease Management Programs

Please call our Care and Disease Management department toll free at 800-327-8613 to enroll your patient/our member. Magellan has programs that will help you more effectively and better self-manage their chronic disease. Some of the programs we offer are:

- Complex Case Management
- Asthma
- Hypertension
- Diabetes
- Cancer
- High Risk Maternity
- HIV/AIDS

Quality Benefit Enhancement Programs

Quality Benefit programs help our members to better their total health. Magellan partners with local community agencies to support:

- Domestic Violence Prevention
- Children’s Programs
- Pregnancy Programs
- Pregnancy Prevention Programs
- Behavioral Health Programs
- Stop Smoking
- Substance Abuse Support

Please call our Provider Relations department toll free at 800-327-8613 for more information. They can assist with providing literature to your office for our members.
Member Rewards Program

Magellan Complete Care wants to encourage our members to make healthy choices and participate in activities that will help them be healthy and keep them from getting sick. As a Magellan Complete Care member, they are eligible for Member Rewards if they take part in specific activities. The goal is to reward their healthy behavior.

Members will receive information on how to earn Member Rewards from their Care Coordination Team. If they leave Magellan Complete Care, rewards can not be transferred to another health plan. They will lose access to earned rewards if they voluntarily disenroll from Magellan Complete Care or lose Medicaid eligibility for more than one-hundred eighty (180) calendar days. For more information, you or the member can call Magellan Complete Care at 800-327-8613.

Continuity of Care Procedures Upon Provider Termination

Magellan Complete Care will notify members within 60 days of the effective date of provider termination without cause. This will include all members who are in a course of active treatment with the provider, assigned to the provider as a PCP, or has prior authorized care with the provider.

Magellan Complete Care will allow the members in active treatment to continue to receive care from the provider until the course of treatment is completed, another provider is selected, or during the next open enrollment period—not to exceed 6 months after the termination date. Pregnant members are permitted to continue the course of treatment until completion of postpartum care. If providers are terminated for cause, notification will occur as soon as practicable (not to exceed 5 business days, but immediately if the member is in imminent danger) and the following continuity of care provisions do not apply.

A terminated provider can refuse to provide care to a member who is abusive or noncompliant. All services provided under the continuity of care provisions will be reimbursed at the rates included in the last active contract.
Medical Records Standards

All Magellan Providers must maintain Medical Records for each member in accordance with the standards as listed below as appropriate. Provider to include all services provided. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases etc.

1. Include the member’s identifying information, including name, member identification number, date of birth, sex, and legal guardianship (if any)
2. Each record must be legible and maintained in detail.
3. Providers must ensure a method for obtaining complete and current patient clinical information and maintaining an updated summary. For example, history and physical form, summary sheet, or checklist. All records must include the history/physical completed including history of procedures and diagnoses.
4. Treatment plans shall reflect evidence-based standards of care and be consistent with the diagnosis for each visit.
5. Include a summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications
6. All entries must be dated and signed by the appropriate party
7. All entries must indicate the chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider
8. All entries must indicate studies ordered (e.g., laboratory, x-ray, EKG) and referral reports
9. All entries must indicate therapies administered and prescribed
10. All entries must include the name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider. All notes written by physician extenders (ARNPs or PAs) must be co-signed by the assigned PCP, indicating their review and approval of the care rendered
11. All entries must include the disposition, recommendations, instructions to the member, evidence of whether there was follow-up and outcome of services
12. All records must contain an immunization history
13. All records must contain information relating to the member’s use of tobacco products and alcohol/substance abuse
14. All records must contain summaries of all Emergency Services and care and hospital discharges with appropriate medically indicated follow up
15. Documentation of referral services must be in member’s Medical Records. This is to include but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases
16. All records must reflect the primary language spoken by the member and any interpretive needs of the member
17. All records must identify members needing communication assistance in the delivery of healthcare services
18. All records must contain documentation that the member was provided with written information concerning the member’s rights regarding Advance Directives (written instructions for living will or power of attorney) and whether or not the member has executed an Advance Directive. Providers cannot, as a condition of treatment, require the member to execute or waive an Advance Directive
19. Copies of any advance directives executed by the member

20. Include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of 13 (thirteen)

21. Example of the Magellan Medical Record Review Form is available in the Forms section of this Provider Manual

22. Provider shall prepare, maintain, and dispose all appropriate medical, administrative, and financial records covering healthcare services provided to each member pursuant to the State and Federal laws

23. Provider shall document follow-up care and record results of studies and therapies and appropriate follow-up according to Magellan Complete Care policies.

Medical Record Confidentiality

Confidentiality of Medical Records Providers will ensure the confidentiality of all medical records in accordance with 42 CFR, Part 431, Subpart F and relevant HIPAA requirements. The confidentiality of a minor’s consultation, examination, and treatment for a sexually transmissible disease must be maintained in accordance with s. 384.30(2), F.S.

Medical Record Review

Magellan Complete Care will audit medical records to determine adherence with Magellan Complete Care standards for documentation and AHCA regulations. Audits will be performed at a minimum of every three years for PCPs that serve ten (10) or more members. Behavioral Health provider’s clinical records will be audited as well. We will also conduct medical record audits on high volume and high impact specialty providers such as OB/GYN, Cardiology and Oncology among others.

Claims and Encounter Submission Protocols (clean claims)

Magellan Complete Care claims and Encounters, including those for behavioral health services will be received and processed by our Midwest Care Management Center which is located at:

Magellan Complete Care
PO Box 2097
Maryland Heights, MO 63043
For all electronically submitted claims, Magellan will:

a. Provide electronic acknowledgement within twenty-four (24) hours after the beginning of the next business day after receipt of the claim to the electronic source submitting the claim.

b. Pay, deny or contest a claim within ten (10) business days after receipt from nursing and hospice facilities. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.

c. Pay, deny or contest a claim within fifteen (15) business days after receipt from a non-nursing/non-hospice facility. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.

Pay or deny the claim within ninety (90) days after receipt of non-nursing facility/non-hospice claim. Failure to pay or deny the claim within one hundred twenty (120) calendar days after receipt of the claim creates an uncontestable obligation for the Health Plan to pay the claim.

For all non-electronically submitted claims, Magellan shall:

a. Within fifteen (15) calendar days after receipt of the claim, provide acknowledgment of receipt of the claim to the provider or designee or provide the provider or designee with electronic access to the status of a submitted claim.

b. Within twenty (20) calendar days after receipt of the claim, pay the claim or notify the provider or designee that the claim is denied or contested. The notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.

c. Pay or deny the claim within one hundred twenty (120) calendar days after receipt of the claim. Failure to pay or deny the claim within one hundred and forty (140) calendar days after receipt of the claim creates an uncontestable obligation for the Health Plan to pay the claim.

Magellan shall reimburse providers for the delivery of authorized services as described in s. 641.3155, F.S., including, but not limited to:

a. The provider must mail or electronically transfer (submit) the claim to Magellan within six (6) months after:
   - The date of service or discharge from an inpatient setting; or
   - The date that the provider was furnished with the correct name and address of the Health Plan.

In accordance with s. 409.912, F.S. Magellan shall reimburse any hospital or physician that is outside the Magellan authorized geographic service area for Health Plan authorized services provided by the hospital or physician to members:

a. At a rate negotiated with the hospital or physician; or

b. The lesser of the following:
   - The usual and customary charge made to the general public by the hospital or physician; or
   - The Florida Medicaid reimbursement rate established for the hospital or physician.
Other Insurance

Medicaid is the payer of last resort. When the Magellan Complete Care is the secondary payer, the provider must submit the claim to the Health Plan within ninety (90) calendar days after the final determination of the primary payer.

- The date of service or discharge from an inpatient setting; or,
- The date that the provider has been furnished with the Electronic Claims Submission

Providers have the option of submitting claims electronically through Electronic Data Interchange (EDI). The advantages of electronic claims submission are as follows:

Magellan shall reimburse providers for Medicare deductibles and co-insurance payments for Medicare dually eligible members according to the lesser of the following:

- The rate negotiated with the provider; or
- The reimbursement amount as stipulated in s. 409.908 F.S.

Filing claims and payment

For appropriate filing information, see “CMS 1500 Claim Forms Instructions” and “UB 04 (or its successor) Claim Form Instructions.” Failure to provide any of the required information can result in payment being delayed. These forms can be found on the Magellan Complete Care provider portal. If you have difficulty accessing these documents, please contact us at 1-800-327-8613.

Magellan will ensure that all claims are processed and payment systems comply with the federal and State requirements set forth in 42 CFR 447.45, 42, CFR 447.46, and Ch. 641.3155, F.S., as applicable. These guidelines are designed to be in compliance with the industry standards, as defined by the CPT-4, ICD-9 and the RBRVS handbooks.

Encounter Data

If a provider is paid on a capitated basis, encounter data must be submitted to the Plan according to the claim submission standards noted above.

This requirement is mandated to meet the reporting requirements of Magellan Complete Care, as well as those established by regulatory agencies and the Balanced Budget Act. Under capitation, encounter data is generally submitted in the form of a claim, and such claims are usually referred to as encounter data.

The Plan will record the encounter data received. The Plan recognizes these services as under a capitated contract and will not make payment to the provider.

The plan is authorized to take whatever steps are necessary to ensure that the provider is recognized by the state Medicaid program, including its choice counseling/enrollment broker contractor(s) as a participating provider of the health plan and that the provider’s submission of encounter data is accepted by the Florida MMIS and/or the state’s encounter data warehouse.

A capitated provider who does not submit encounter data is subject to corrective action measures and penalties under applicable state and federal law and could be terminated from the Plan.

Magellan is committed to providing the most accurate, up to date information. Please call Magellan Complete Care Provider Services at 800-327-8613 for information or assistance regarding the status of any claim.
Provider Portal

Magellan Complete Care offers a secure Provider Portal to access member eligibility and PCP information. Providers can also submit and view claim status. Other options include downloading explanation of benefits (EOBs) and accessing tools such as Medicaid Disclosure Form. Magellan Complete Care encourages providers to use the portal as this is a free of charge service and accessible 24/7. To obtain username and password, please call Provider Service Line at 1-800-788-4005.

Protocols for Submitting Claims and Encounters

Magellan Complete Care continuously encourages providers to submit claims and encounters electronically. Electronic submission is less costly for the providers. Our team is trained in options for submission and is happy to schedule time with providers with questions or concerns about this method of submission. Magellan will also reach out to providers if the Agency denies encounter submissions to make the appropriate adjustments to their encounter data.

Information on submission of clean claims, claims do's and don'ts, etc. are available on the Magellan provider portal.

Claims and encounters can be submitted:

- Via our Direct Submit capability, allowing providers to submit claims files through a secure FTP connection or the Magellan website
- Via clearinghouse. Magellan obtains support from multiple clearinghouses in order to provide redundancy and to offer a broad range of options for our providers. Our payer ID is 01260 for Emdeon and all other clearinghouses.
- Via mail to the address below:
  Magellan Complete Care
  PO Box 2097
  Maryland Heights, MO 63043
  Claims inquiry line: 800-327-8613

Preferred Drug List

Please visit Magellan Complete Care’s website for the most recent Preferred Drug List at MCCofFL.com.

Supporting Efforts to Connect with Members

Consumer advocates and accreditation bodies are asking organizations and providers to become innovators in member services and increase the use of secure technology to make accessing services more convenient for members. Magellan Complete Care supports this goal and encourages you to consider how you can use technology in these areas of service:

**E-visit**—email communication between providers and members after the first face-to-face visit has taken place.

**E-prescribing**—the physician sends a prescription directly to the member’s pharmacy.

**Refill reminders**—email notification to remind members to refill their medications.

**E-appointment**—members are able to schedule appointments electronically.

**Online personal health records**—members are able to keep track of their personal health information.
The Patient’s Right to Decide

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer’s disease), they are considered incapacitated. To make sure that an incapacitated person’s decisions about healthcare will still be respected, the Florida legislature enacted legislation pertaining to healthcare advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death.

By law hospitals, nursing homes, home health agencies, hospices, and health maintenance organizations (HMOs) are required to provide their patients with written information, such as this pamphlet, concerning healthcare advance directives. The state rules that require this include 58A-2.0232, 59A-3.254, 59A-4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code.

Questions About Healthcare Advance Directives

What is an advance directive?
It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Three types of advance directives are:
• A Living Will
• A Healthcare Surrogate Designation
• An Anatomical Donation

You might choose to complete one, two, or all three of these forms. This pamphlet provides information to help you decide what will best serve your needs.

What is a living will?
It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your healthcare provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a healthcare surrogate designation?
It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.
Which is best?
Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives.

What is an anatomical donation?
It is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for training of healthcare workers. You can indicate your choice to be an organ donor by designating it on your driver’s license or state identification card (at your nearest driver’s license office), signing a uniform donor form (seen elsewhere in this pamphlet), or expressing your wish in a living will.

Am I required to have an advance directive under Florida law?
No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your healthcare or an anatomical donation may be made for you by a court-appointed guardian, your wife or husband, your adult child, your parent, your adult sibling, an adult relative, or a close friend.

The person making decisions for you may or may not be aware of your wishes. When you make an advance directive, and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

Must an attorney prepare the advance directive?
No, the procedures are simple and do not require an attorney, though you may choose to consult one.

However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

Where can I find advance directive forms?
Florida law provides a sample of each of the following forms: a living will, a healthcare surrogate, and an anatomical donation. Elsewhere in this pamphlet we have included sample forms as well as resources where you can find more information and other types of advance directive forms.

Can I change my mind after I write an advance directive?
Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated. However, you can also change an advance directive by oral statement; physical destruction of the advance directive; or by writing a new advance directive.

If your driver’s license or state identification card indicates you are an organ donor, but you no longer want this designation, contact the nearest driver’s license office to cancel the donor designation and a new license or card will be issued to you.

What if I have filled out an advance directive in another state and need treatment in Florida?
An advance directive completed in another state, as described in that state’s law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?
• If you designate a healthcare surrogate and an alternate surrogate be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.
• Make sure that your healthcare provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You also may want to give them a copy.
Set up a file where you can keep a copy of your advance directive (and other important paperwork). Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.

Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.

If you change your advance directive, make sure your healthcare provider, attorney and the significant persons in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your healthcare provider, attorney, or the significant persons in your life.

More Information On Healthcare Advance Directives

Before making a decision about advance directives you might want to consider additional options and other sources of information, including the following:

As an alternative to a healthcare surrogate, or in addition to, you might want to designate a durable power of attorney. Through a written document you can name another person to act on your behalf. It is similar to a healthcare surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You can consult an attorney for further information or read Chapter 709, Florida Statutes.

If you choose someone as your durable power of attorney be sure to ask the person if he or she will agree to take this responsibility, discuss how you would like matters handled, and give the person a copy of the document.

If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies people who do not wish to be resuscitated from respiratory or cardiac arrest. The pre-hospital DNRO is a specific yellow form available from the Florida Department of Health (DOH). Your attorney, healthcare provider, or an ambulance service may also have copies available for your use. You, or your legal representative, and your physician sign the DNRO form. More information is available on the DOH website, www.doh.state.fl.us or www.MyFlorida.com (type DNRO in these website search engines) or call (850) 245-4440.
• When you are admitted to a hospital the pre-hospital DNRO may be used during your hospital stay or the hospital may have its own form and procedure for documenting a Do Not Resuscitate Order.

• If a person chooses to donate, after death, his or her body for medical training and research the donation will be coordinated by the Anatomical Board of the State of Florida. You, or your survivors, must arrange with a local funeral home, and pay, for a preliminary embalming and transportation of the body to the Anatomical Board located in Gainesville, Florida. After being used for medical education or research, the body will ordinarily be cremated. The cremains will be returned to the loved ones, if requested at the time of donation, or the Anatomical Board will spread the cremains over the Gulf of Mexico. For further information contact the Anatomical Board of the State of Florida at 800-628-2594 or www.med.ufl.edu/anatbd.

• If you would like to learn more on organ and tissue donation, please visit the Joshua Abbott Organ and Tissue Donor Registry at www.DonateLifeFlorida.org where you can become organ, tissue and eye donors online. If you have further questions about organ and tissue donation you may want to talk to your healthcare provider.

Various organizations also make advance directive forms available. One such document is “Five Wishes” that includes a living will and a healthcare surrogate designation. “Five Wishes” gives you the opportunity to specify if you want tube feeding, assistance with breathing, pain medication, and other details that might bring you comfort such as what kind of music you might like to hear, among other things. You can find out more at:

Aging with Dignity
www.AgingWithDignity.org
888-594-7437

Other resources include:
American Association of Retired Persons (AARP)
www.aarp.org
(Type “advance directives” in the website’s search engine)

Your local hospital, nursing home, hospice, home health agency, and your attorney or healthcare provider may be able to assist you with forms or further information.

Brochure: End of Life Issues
www.FloridaHealthFinder.gov
888-419-3456
Helpful Forms
Magellan Complete Care, your health plan, wants to help you feel better and enjoy a healthy life.

These health questions will help us to better understand how you are feeling. It will help us know what services and resources you will need to stay healthy and feel well. The questions will take you about 15 minutes to complete. If you do not understand any of the questions or need help with the form, please call us at 800-327-8613.

As your health plan it is key that we work very closely with your doctors. We make sure you get the care you need. If you give us the OK, we can share this information with your doctors. This will make sure you get good care and help your doctors talk to each other. Without your OK, we will not share any information with anyone.

Do you agree for us to share this information with your doctors?  ○ Yes  ○ No

*Fields mark with an * are required.*

Date completed: ____________________________

### About You

- **Enrollee’s Name:**
- **Medicaid ID #:**
- **Date of Birth:**
- Age:
- Social Security #: 

What language do you, your family, or caregiver speak?  

- **Race/Ethnicity:**

- **Sex:**  ○ Male  ○ Female  

- **Date of Enrollment:**

- **Address:**

- **Home Phone #:**
- Cell Phone #:
- Email:

- **Veteran:**  ○ Yes  ○ No

- **Veteran Discharge Status:**  ○ Honorably  ○ Dishonorably

Do you reside in an ALF?  ○ Yes  ○ No  
If so, which one?

Other Insurance:  ○ Medicare  ○ Long Term Care  ○ Waiver Program  ○ Other

- **How did you hear about Magellan Complete Care?**

- **Did anyone offer you an incentive to join the plan?**  ○ Yes  ○ No

Details:

- **Do you have reliable transportation to your medical appointments?**  ○ Yes  ○ No  ○ Unsure

- **Best day/time to reach you?**

- **How do you like to talk with providers about your health?**

  ○ Telephone  ○ Email  ○ Face to Face  ○ Text Message  ○ Mail

- **Where do you currently live?** *(select all that apply)*

  ○ House  ○ Apartment  ○ Assisted Living  ○ Shelter  ○ Homeless  ○ Supervised

- **Who do you live with?** *(select all that apply)*

  ○ Alone  ○ Roommate  ○ Partner/spouse  ○ Adult family  ○ Minor children
# About Your Physical Health

<table>
<thead>
<tr>
<th>*Height (inches):</th>
<th>*Weight (lbs):</th>
</tr>
</thead>
</table>

*Based on your age, how would you rate your overall health?  ○ Poor  ○ Not Good  ○ Average  ○ Good  ○ Excellent

*Do you have any concerns about your health or physical well-being?  ○ Yes  ○ No  ○ Unsure

Details:

Do you have any of the following:

- ○ Allergies
- ○ Asthma
- ○ Back Pain
- ○ Bipolar Disorder
- ○ Bronchitis
- ○ Cancer
- ○ Chronic Pain
- ○ Depression
- ○ Diabetes
- ○ Heart Problems
- ○ Hearing Impaired
- ○ Hepatitis C
- ○ High Blood Pressure
- ○ HIV/AIDS
- ○ Kidney Disease
- ○ Liver Disease
- ○ Obsessive Compulsive Disorder
- ○ Reflux/Heartburn
- ○ Schizoaffective Disorder
- ○ Schizophrenia
- ○ Sickle Cell Anemia
- ○ Stroke
- ○ Transplant
- ○ Visually Impaired
- ○ Other:  

Are you currently pregnant?  ○ Yes  ○ No  ○ Unsure

Estimated due date:

# About Care You Receive

*How many times have you been seen in the Emergency Room in the last 3 months?  ○ 0  ○ 1  ○ 2  ○ More than 2

*How many times have you been admitted to the hospital in the past 30 days?  ○ 0  ○ 1  ○ 2  ○ More than 2

*How many times have you been admitted to the hospital in the past 3 months?  ○ 0  ○ 1  ○ 2  ○ More than 2

*Do you currently need or use medicine prescribed by a doctor (other than vitamins) for ANY medical, behavioral or other health condition?  ○ Yes  ○ No  ○ Unsure

Medication List:

Are these medications effective in managing your health conditions?  ○ Yes  ○ No  ○ Unsure

*Do you use any medical equipment, such as glucometer, nebulizer, wheelchair, hospital bed?  ○ Yes  ○ No  ○ Unsure

*What is the name of your primary care provider?  ○ PCP Name:  ○ N/A

*What is the name of your primary behavioral health provider?  ○ PBHP Name:  ○ N/A

*What is the name of your dentist?  ○ Dentist Name:  ○ N/A

What are the names of your other healthcare providers? *If applicable*:

Have you had any of the following done in the last 12 months?

- ○ Routine Physical Exam
- ○ Routine Eye Exam
- ○ Flu Vaccination
- ○ Dental exam
- ○ Mammogram (women)
- ○ Cervical Cancer Screening (PAP test)
- ○ Colorectal Cancer Screening
- ○ Rectal or prostate exam
- ○ Prostate Cancer Screening (PSA)
About Your Lifestyle

*Have you gained or lost more than 10 lbs. in the last six months?  ○ Yes  ○ No  ○ Unsure

Details:

*How many meals do you eat in a usual day?  ○ Fewer than 3  ○ 3  ○ 4 to 6  ○ More than 6

*How many servings per day do you eat for each of the food types below?

<table>
<thead>
<tr>
<th>Food Type</th>
<th>0</th>
<th>1–2</th>
<th>3–4</th>
<th>5 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breads, cereal, pasta, rice, other grains</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Fruits</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Vegetables</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Milk, cheese, yogurt</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Meat, poultry, fish, eggs</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Lentils, beans, tofu</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Peanut butter, nuts</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Fats such as margarine, mayonnaise, sour cream</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Oils</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Fried foods or salty snack foods such as chips</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Desserts</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

*Which best describes your use of tobacco products?

○ Never used  ○ Current user trying to quit  ○ Current user not trying to quit  ○ Previous user

*How many drinks of alcohol do you have in a typical week? (A drink = 12 oz. of beer, a 5 oz. glass of wine, a 12 oz. wine cooler, or a shot of whisky)  ○ None  ○ 1 to 7  ○ 8 to 14  ○ > 14

*Do you have any substance abuse concerns?  ○ Yes  ○ No  ○ Unsure

Details:

*How would you describe your physical activity/exercise level?  ○ High  ○ Moderate  ○ Low

*In an average week how many times do you engage in physical activity that lasts at least 20 minutes without stopping?

○ None  ○ 1 to 2 times  ○ 3 to 4 times  ○ 5 or more times

*On average how many hours of sleep do you get per night?

○ Less than 5  ○ More than 5 hours but less than 7 hours  ○ 7 to 8 hours  ○ More than 8 hours

*How many days have you missed from work or school in the last three months?

○ 1–2 days  ○ 3–5 days  ○ 6 or more days

*How much has your overall health hurt work/school performance in the last three months?

○ Never  ○ Sometimes  ○ A lot  ○ All of the time
### About Your Emotional Health

<table>
<thead>
<tr>
<th>How often do you feel stressed?</th>
<th>Never</th>
<th>Sometimes</th>
<th>A lot</th>
<th>All of the time</th>
</tr>
</thead>
</table>

*Are you exposed to physical or emotional abuse?  
   - Yes
   - No
   - Unsure

**Details:**

*Do you have any financial concerns that may impact your healthcare needs (i.e. affording medications, food, heat, limited income etc.)?  
   - Yes
   - No
   - Unsure

**Details:**

Over the past 2 weeks, how often have you been bothered by any of the following problems?  

<table>
<thead>
<tr>
<th>Little interest or pleasure in doing things</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling down, depressed or hopeless</td>
<td>Not at all</td>
<td>Several days</td>
<td>More than half days</td>
<td>Nearly every day</td>
</tr>
</tbody>
</table>

### About Your Future Health

*How sure are you that you can keep symptoms or health problems from getting in the way of the things you want to do?  
   - Not sure
   - Somewhat sure
   - Very sure

*Are you already taking steps or action to improve your health?  
   - Yes
   - No
   - Unsure

*Are you thinking about making changes to improve your health?  
   - Yes
   - No
   - Unsure
Child Health Assessment

Magellan Complete Care, your health plan, wants to help you or your child feel better and enjoy a healthy life.

These health questions will help us to better understand how you or your child is feeling. It will help us know what services and resources you will need to stay healthy and feel well. The questions will take you about 15 minutes to complete. If you do not understand any of the questions or need help with the form, please call us at 800-327-8613.

As your or your child’s health plan it is key that we work very closely with your doctors. We make sure you get the care you need. If you give us the OK, we can share this information with your or your child’s doctors. This will make sure you your child gets good care and help your (your child’s) doctors talk to each other. Without your OK, we will not share any information with anyone.

Do you agree for us to share this information with your doctors?  ○ Yes  ○ No

Fields marked with an * are required.

Date completed:__________________________

About You/Your Child

<table>
<thead>
<tr>
<th>*Enrollee’s Name:</th>
<th>*Medicaid ID #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Date of Birth:</td>
<td>Age: Social Security #:</td>
</tr>
<tr>
<td>What language do you, your family, or caregiver speak?</td>
<td>Race/Ethnicity:</td>
</tr>
<tr>
<td>*Sex:  ○ Male  ○ Female</td>
<td>*Date of Enrollment: Guardian:</td>
</tr>
<tr>
<td>*Address:</td>
<td></td>
</tr>
<tr>
<td>*Home Phone #:</td>
<td>Cell Phone #: Email:</td>
</tr>
<tr>
<td>*Veteran:  ○ Yes  ○ No</td>
<td>Veteran Discharge Status:  ○ Honorably  ○ Dishonorably</td>
</tr>
<tr>
<td>Do you (your child) reside in an ALF?  ○ Yes  ○ No If so, which one?</td>
<td></td>
</tr>
<tr>
<td>Other Insurance:  ○ Medicare  ○ Long Term Care  ○ Waiver Program  ○ Other</td>
<td></td>
</tr>
<tr>
<td>*How did you hear about Magellan Complete Care?</td>
<td></td>
</tr>
<tr>
<td>*Did anyone offer you something to join the plan?  ○ Yes  ○ No Details:</td>
<td></td>
</tr>
<tr>
<td>*Do you have reliable transportation to your (your child’s) medical appointments?  ○ Yes  ○ No  ○ Unsure</td>
<td></td>
</tr>
<tr>
<td>*Best day/time to reach you?</td>
<td></td>
</tr>
<tr>
<td>*How do you like to talk with providers about your (your child’s) health?  ○ Telephone  ○ Email  ○ Face to Face  ○ Text Message  ○ Mail</td>
<td></td>
</tr>
<tr>
<td>*Where do you (or your child) currently live? (select all that apply)  ○ House  ○ Apartment  ○ Assisted Living  ○ Shelter  ○ Homeless  ○ SIPP  ○ Other</td>
<td></td>
</tr>
<tr>
<td>*Who do you (or your child) live with? (select all that apply)  ○ Mother  ○ Father  ○ Both parents  ○ Relative/friend  ○ Protective custody  ○ Foster care  ○ Other</td>
<td></td>
</tr>
</tbody>
</table>
## About You/Your Child’s Physical Health

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>How tall (inches) are you (your child)?</td>
<td>How much do you (your child) weigh (lbs)?</td>
</tr>
<tr>
<td>*Do you have any concerns about your (your child’s) health or physical well-being?</td>
<td>○ Yes ○ No ○ Unsure</td>
</tr>
<tr>
<td>*How much do you think your (your child’s) overall health has harmed learning and work at school over the last 3 months?</td>
<td>○ No harm ○ A little harm ○ Moderate harm ○ Quite a lot of harm ○ Major harm ○ Not applicable</td>
</tr>
<tr>
<td>How many days of school have you (your child) missed in the last 4 weeks due to physical or mental health problems?</td>
<td>○ Allergies ○ Asthma ○ Anxiety ○ Autism/Autism Spectrum Disorder ○ Back Pain ○ Bipolar Disorder ○ Bronchitis ○ Cancer ○ Cerebral Palsy ○ Chronic Pain ○ Cystic Fibrosis ○ Depression ○ Diabetes ○ Down Syndrome ○ Epilepsy/Seizure Disorder ○ Heart Problems ○ Hearing Impaired ○ Hemophilia ○ Hepatitis C ○ High Blood Pressure ○ HIV/AIDS ○ Kidney Disease ○ Learning Disabilities ○ Liver Disease ○ Obsessive Compulsive Disorder ○ Reflux/Heartburn ○ Schizoaffective Disorder ○ Schizophrenia ○ Sickle Cell Anemia ○ Stroke ○ Transplant ○ Visually Impaired ○ Other:</td>
</tr>
<tr>
<td>Are you (your child) currently pregnant?</td>
<td>○ Yes ○ No ○ Unsure</td>
</tr>
<tr>
<td>Estimated due date:</td>
<td></td>
</tr>
</tbody>
</table>

## About Care You Receive

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>*How many times have you been seen in the Emergency Room in the last 3 months?</td>
<td>○ 0 ○ 1 ○ 2 ○ More than 2</td>
</tr>
<tr>
<td>*How many times have you been admitted to the hospital in the past 30 days?</td>
<td>○ 0 ○ 1 ○ 2 ○ More than 2</td>
</tr>
<tr>
<td>*How many times have you been admitted to the hospital in the past 3 months?</td>
<td>○ 0 ○ 1 ○ 2 ○ More than 2</td>
</tr>
<tr>
<td>*Have you (your child) had any major falls or injuries in the last 6 months?</td>
<td>○ Yes ○ No ○ Unsure</td>
</tr>
<tr>
<td>*Do you (your child) use any medical equipment, such as glucometer, nebulizer, wheelchair, hospital bed?</td>
<td>○ Yes ○ No ○ Unsure</td>
</tr>
<tr>
<td>*Do you (your child) currently need or use medicine prescribed by a doctor (other than vitamins) for ANY medical, behavioral or other health condition?</td>
<td>○ Yes ○ No ○ Unsure</td>
</tr>
<tr>
<td>Medication List:</td>
<td></td>
</tr>
<tr>
<td>Are these medications effective in managing your (your child’s) health conditions?</td>
<td>○ Yes ○ No ○ Unsure</td>
</tr>
<tr>
<td>*What is the name of your (your child’s) primary care provider?</td>
<td>○ PCP Name: ○ N/A</td>
</tr>
<tr>
<td>*What is the name of your (your child’s) primary behavioral health provider?</td>
<td>○ PBHP Name: ○ N/A</td>
</tr>
<tr>
<td>*What is the name of your (your child’s) dentist?</td>
<td>○ Dentist Name: ○ N/A</td>
</tr>
</tbody>
</table>
What are the names of your (your child’s) other healthcare providers? *(If applicable):*

Have you had any of the following done in the last 12 months?

- [ ] Routine Physical Exam (CHCUP)  *Date:*
- [ ] Routine Eye Exam
- [ ] Dental Exam  *Date:*
- [ ] Lead Screening
- [ ] Flu Vaccination
- [ ] Tetanus Vaccination
- [ ] Cervical Cancer Screening (PAP test)
- [ ] Blood Pressure Check

Last blood pressure reading:

**About Your/Your Child’s Lifestyle**

*Have you (your child) gained or lost more than 10 lbs. in the last six months?  ○ Yes  ○ No  ○ Unsure*

*How many meals do you (your child) eat in a usual day?  ○ Fewer than 3  ○ 3  ○ 4 to 6  ○ More than 6*

*How many servings per day do you (your child) eat for each of the food types below?*

<table>
<thead>
<tr>
<th>Food Type</th>
<th>0</th>
<th>1 – 2</th>
<th>3 – 4</th>
<th>5 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breads, cereal, pasta, rice, other grains</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fruits</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vegetables</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milk, cheese, yogurt</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meat, poultry, fish, eggs</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lentils, beans, tofu</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peanut butter, nuts</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fats such as margarine, mayonnaise, sour cream</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oils</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fried foods or salty snack foods such as chips</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desserts</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

My (your child’s) physical activity/exercise level  ○ High  ○ Moderate  ○ Low

*On average how many hours of sleep do you (your child) get per night?*

- [ ] Less than 5  ○ More than 5 hours but less than 7 hours  ○ 7 to 8 hours  ○ More than 8 hours

*Do you (your child) currently use tobacco products?  ○ Yes  ○ No  ○ Unsure*

*Are there any substance abuse concerns for you (your child)?  ○ Yes  ○ No  ○ Unsure*

*How much do you think your (your child’s) overall health has hurt learning and work at school over the last 3 months?*

- [ ] Never  ○ Sometimes  ○ A lot  ○ All of the time

* How many days of school have you (your child) missed in the last 4 weeks due to physical or mental health problems?

- [ ] 1 – 2 days  ○ 3 – 5 days  ○ 6 or more days
### About Your Emotional Health

- Are there any physical or emotional abuse/neglect concerns for you (your child)?  
  - Yes  
  - No  
  - Unsure

- Do you (your child) have any trouble with emotions, behaving, learning, focusing or getting along with others?  
  - Yes  
  - No  
  - Unsure

- Have you (your child) been sent to juvenile detention or jail?  
  - Yes  
  - No  
  - Unsure

- Do you (your child) receive any services from the Special Education Services through your school district? (Children receiving these services often have an Individualized Education Plan (IEP)).  
  - Yes  
  - No  
  - Unsure

- Are there any financial concerns that may impact your (your child's) health care needs (i.e. affording medications, food, heat, limited income etc.)?  
  - Yes  
  - No  
  - Unsure

- Do you (your child) have little interest or pleasure in doing things  
  - Not at all  
  - Several days  
  - More than half days  
  - Nearly every day

- Do you (your child) feel down, depressed or hopeless  
  - Not at all  
  - Several days  
  - More than half days  
  - Nearly every day

### About Your Future Health

- Are you already taking steps or action to improve your (your child's) health?  
  - Yes  
  - No  
  - Unsure

- Are you thinking about making changes to improve your (your child's) health?  
  - Yes  
  - No  
  - Unsure
Grievance Form

Mail to: Magellan Complete Care
Attn: Grievance and Appeals Department
PO Box 524083
Miami, FL 33152

Need assistance? Please call 800-327-8613 or our TTY number at 800-424-1694

Member Name: | Member ID:
Address:

Cell Phone Number: | Home Telephone Number:

Date problem occurred:

Where did this happen:

Did you call anyone at Magellan or the doctor’s office for help?  Yes  No
If yes, what’s their name and telephone number?
Name: | Telephone Number:

Please describe the problem that you experienced:

Did you ask anyone to resolve the problem you encountered?  Yes  No

What’s the best time to speak with you?  8:30 am—12:30 pm  1:00 pm –5:00 pm

I understand that Magellan Complete Care will (1) contact me within 5-working days of receipt of this form; (2) I will be notified by Magellan Complete Care regarding their initial findings; (3) I will be notified of my Rights to an appeal if I’m not satisfied with Magellan Complete Care’s findings.

----------------------------------------------------------------------------------------------------------------------------------
Signature of Member/Representative/Legal Guardian                      Date

----------------------------------------------------------------------------------------------------------------------------------
Print Name of Member/Representative/Legal Guardian

Contact Telephone Number: | Relationship if not Member:
Appeals Form

Thank you for contacting Magellan Complete Care. All appeals must be submitted in writing to:

Magellan Complete Care
Attn: Grievance and Appeals Department
PO Box 524083
Miami, FL 33152

Need assistance? Please call 800-327-8613 or our TTY number at 800-424-1694

Member Name: | Member ID:
Address:

Cell Phone Number: | Home Telephone Number:

The following items are included with my appeal:

☐ Copy of the original claim
☐ Medical Records enclosed
☐ Proof of Eligibility
☐ Prior authorization from Magellan Complete Care
☐ Other documents

What's the best time to speak with you?  ☐ 8:30 am—12:30 pm  ☐ 1:00 pm—5:00 pm

I have received a copy of my Appeal Rights in my Member Handbook. If I need assistance with understanding my Rights, Magellan Complete Care will assist in explaining this to me.

_________________________________________________________  _______________________
Signature of Member/Representative/Legal Guardian          Date

_________________________________________________________
Print Name of Member/Representative/Legal Guardian

Contact Telephone Number: | Relationship if not Member:

Type of Appeal:  ☐ Regular appeal  ☐ Expedited appeal (must demonstrate proof of medical emergency)
Florida WIC Program Medical Referral Form

Shaded areas must be completed. See instructions for completing this form on the reverse side.

Is this client eligible for Healthy Start? ☐ Yes ☐ No
For WIC Office Use Only:
Date of WIC Certification Appointment

Client’s Name ________________________ Birth Date ___________ Sex M F
Address ______________________________ Phone Number (______) ______-________
City __________________ Zip Code _____ Social Security # ______-____-_____
Parent’s/Guardian’s Name __________________________ (for infants and children only)

☐ For Pregnant Women
Height ______ inches Weight ______ lb Date Taken ____________ (no older than 60 days)
Hemoglobin _______ OR Hematocrit _______ Date Taken ____________ (must be during current pregnancy)
Expected Date of Delivery ____________ Date of First Prenatal Visit ____________ Prepregnancy Weight _______

☐ For Breastfeeding and Postpartum (Non-Breastfeeding) Women
Height ______ inches Weight ______ lb Date Taken ____________ (no older than 60 days)
Hemoglobin _______ OR Hematocrit _______ Date Taken ____________ (must be in postpartum period)
Date of Delivery ____________ Date of First Prenatal Visit ____________ Weight at Last Prenatal Visit _______

☐ For Infants and Children less than 24 months of age
Birth Weight ______ lb ______ oz Birth Length _______ inches
Current Height ______ inches Current Weight ______ lb Date Taken ____________ (no older than 60 days)
Hemoglobin _______ OR Hematocrit _______ Date Taken ____________ (required once between 6 to 12 months
AND once between 12 to 24 months)

☐ For Children 2 to 5 years of age
Height ______ inches Weight ______ lb Date Taken ____________ (no older than 60 days)
Hemoglobin _______ OR Hematocrit _______ Date Taken ____________ (once a year unless value < 11.1 Hgb or
< 33% Hct, then required in 6 months)

✓ Check all that apply. Please refer your client to WIC, even if nothing is checked below. This information
assists the WIC nutritionist in determining eligibility, developing a nutrition care plan, and providing nutrition counseling. WIC staff
may need to contact you or your staff to obtain more detailed medical information prior to providing WIC services.

☐ Medical condition (specify) __________________________
☐ Food allergy (specify) __________________________
☐ Current or potential breastfeeding complications (specify) __________________________
☐ Recent major surgery, trauma, burns (specify) __________________________
☐ Other (specify) __________________________

☐ Nutrition Counseling Requested – specify diet prescription/order __________________________

WIC Local Agency Address:
I refer this client for WIC eligibility determination:
Signature/Title of Health Professional __________________________
Date ____________ PLEASE PLACE OFFICE STAMP BELOW:
Address:
Phone Number:

***Parent or Guardian: Please bring a copy of your baby’s/child’s shot record to the WIC office.***

DH 3075, 4/14 Florida Department of Health WIC Program
USDA is an equal opportunity provider and employer.
Instructions for Completing the Florida WIC Program Medical Referral Form

All shaded areas must be completed in order for the form to be processed.

1. Check (✓) YES if the client has been screened and is eligible for Healthy Start. Check (✓) NO if the client is not eligible for Healthy Start. Leave blank if the client has not been screened. Note: Eligibility for Healthy Start does not affect a client's eligibility for WIC.

2. Complete the client’s name and birth date.

3. Optional Information: the client's sex, mailing address, phone number, city, zip code, social security number, and the parent's or guardian's name for infants and children.

4. Complete the appropriate shaded section for the client.

**Pregnant Women:** Complete the height and weight measurements and the date they were taken. These measurements are to be taken no more than 60 days before the client’s WIC appointment. (The WIC appointment may be recorded at the top of the form.) Complete the hemoglobin or hematocrit value and the date the value was taken. There is no limit on how old the bloodwork data can be, as long as the measurement was taken during the current pregnancy. Complete the expected date of delivery, the date of the client's first prenatal visit, and the prepregnancy weight.

**Breastfeeding Women** (eligible up to one year after delivery) and **Postpartum Women—Non-Breastfeeding** (eligible up to 6 months after delivery/termination of pregnancy): Complete the height and weight measurements and the date they were taken. These measurements are to be taken no more than 60 days before the client's WIC appointment. (The WIC appointment may be recorded at the top of the form.) Complete the hemoglobin or hematocrit value and the date the value was taken. There is no limit on how old the bloodwork data can be, as long as the bloodwork is taken after delivery of the most recent pregnancy. Complete the actual date of delivery, the date of the first prenatal visit, and the weight measurement at the last prenatal visit.

**Infants and Children less than 24 months of age:** Complete the infant's birth weight and birth length. Complete the current height and weight measurements and the date they were taken. These measurements are to be taken no more than 60 days before the client's WIC appointment. (The WIC appointment may be recorded at the top of the form.) Complete the hemoglobin or hematocrit value and the date the value was taken. A bloodwork value is required once during infancy between 6 to 12 months of age (preferably between 9 to 12 months of age) and once between 1 to 2 years of age (preferably 6 months from the infant bloodwork value).

**Children 2 to 5 years of age:** Complete the current height and weight measurements and the date they were taken. These measurements are to be taken no more than 60 days before the client’s WIC appointment. (The WIC appointment may be recorded at the top of the form.) Complete the hemoglobin or hematocrit value and the date the value was taken. A bloodwork value is required once a year unless the value is abnormal (< 11.1 hemoglobin or < 33% hematocrit), then a bloodwork value is required in 6 months.

5. Check (✓) any health problem that you have identified. **Even if you have not identified a health problem, refer the client to the WIC program.**

6. If you would like a nutritionist to counsel your client on a specific diet, check the box and specify the diet prescription or diet order requested.

7. If possible, please provide a copy of the immunization record for infant and child clients.

8. Complete the shaded area at the bottom of the form with the signature of the health professional taking the measurement or his/her designee and the office address and phone number. Stamp the form with the office stamp or the health professional's stamp.

9. Give this completed form to the client or parent/guardian to bring to the WIC certification appointment or mail/fax the form to the local WIC agency address shown in the bottom left corner of the form.
The Florida WIC Program supports the American Academy of Pediatrics' Statement on Breastfeeding and the Use of Human Milk. Final determination of the approval and provision of formula and food will be based on Florida WIC Program policies and procedures.

Client's Name: ___________________________________________ Date of Birth: ________________________

FORMULA(S) and FOOD OPTIONS
Please read the back of this form for Florida WIC policies and list of qualifying medical conditions.

Enfamil milk-based formulas and Gerber soy-based formulas are the WIC contract formulas. (See the back of this form for more information about the WIC contract formulas.)

To request a substitute, complete all fields below.

Have WIC contract formulas been tried? □ Yes □ No Are they contraindicated? □ Yes □ No

Why? ____________________________________________________________

Formula Name: ____________________________________ □ maximum amount allowed OR specify ounces required per day ______

Formula Name: ____________________________________ □ maximum amount allowed OR specify ounces required per day ______

Do not issue WIC supplemental foods; provide formula only.

Licensed Dietitian/Nutritionist can determine which WIC supplemental foods to provide.

Child 1 year or older who is prescribed a formula requires the following WIC supplemental foods checked below:

□ Baby cereal AND baby fruits and vegetables □ Baby cereal AND regular fruits and vegetables

Issue a modified food package omitting the WIC supplemental foods checked below:

Infant under 1 year: □ No baby cereal at 6 months of age □ No baby fruits and vegetables at 6 months of age

Woman or Child 1 year or older: □ No milk □ No yogurt (only provided for women & children 2 years and older) □ No cheese

□ No fruit juice □ No beans □ No cereal □ No whole wheat bread/pasta/tortillas; brown rice; or corn tortillas □ No eggs

□ No fruits & vegetables □ No peanut butter (only provided for women & children 2 years and older) □ No fish (only provided for some women)

Any special instructions or additional restrictions:

______________________________________________________

Length of use (cannot exceed 6 months): □ 1 month □ 3 months □ 6 months □ Other, please specify __________________

Qualifying medical condition(s):

_________________________________________________________________________________________________

_________________________________________________________________________________________________

Date Anthropometric data obtained: ___________ Height or Length: _______inches Weight: _______ lbs

Failure to Thrive must be accompanied by current height or length and weight.

MILK SUBSTITUTES and OPTIONS - Only complete this section when applicable.

Child 1 year to less than 2 years old - WIC provides whole cow's milk OR whole lactose-free cow's milk.

□ Soy formula instead of cow's milk and cheese for: □ Cow’s milk allergy □ Vegan diet □ Lactose intolerance

Check which soy formula: □ Gerber Graduates Soy □ Gerber Good Start Soy □ Other

Woman or Child 2 years or older - WIC provides 1% lowfat or fat free cow's milk OR 1% lowfat or fat free lactose-free cow's milk OR soy milk.

If prescribing a formula for a woman or child 1 year or older, what type of milk do you want WIC to provide?

□ Whole milk □ 1% lowfat or fat free milk □ 2% reduced fat milk □ No milk

Any special instructions or additional restrictions:

_________________________________________________________________________________________________

Must have office stamp or complete practice address and phone number

Print Name ___________________________ Phone Number ___________________________

Signature of Physician, ARNP, or PA ___________________________ Date ___________________________

DH 3110, 7/15 (Replaces the 2014 editions which may be used.)
Dear Health Care Provider:

Thank you for your continuing support of the Florida WIC Program. WIC supports the American Academy of Pediatrics' Statement on Breastfeeding and the Use of Human Milk. WIC encourages mothers to fully breastfeed their babies for about 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant. Local WIC agency staff can assist WIC mothers with breastfeeding or make appropriate referrals.

The Florida WIC Program provides a limited number of milk-based and soy-based formulas for WIC infants who are not fully breastfeeding. (See list of WIC contract formulas below.) The use of federally mandated competitive procurement for standard infant formulas has allowed the program to purchase formula at a greatly reduced cost. Use of the WIC contract formulas provides additional funds for the Florida WIC Program to serve more pregnant, breastfeeding, and postpartum women; infants; and children.

Completion of this form is not needed for infants under 12 months of age to receive a WIC contract formula.

**WIC contract standard infant formulas are the following formulas:**

<table>
<thead>
<tr>
<th>Formula</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Enfamil Newborn</em></td>
<td>milk-based formula, 80:20 whey-to-casein ratio, with increased vitamin D per ounce (400 IU vitamin D in 27 oz)</td>
</tr>
<tr>
<td><em>Enfamil Infant</em></td>
<td>milk-based formula, 60:40 whey-to-casein ratio (400 IU vitamin D in 34 oz)</td>
</tr>
<tr>
<td><em>Enfamil Gentlease</em></td>
<td>partially hydrolyzed milk-based formula, 60:40 whey-to-casein ratio, 20% lactose</td>
</tr>
<tr>
<td><em>Enfamil Reguline</em></td>
<td>partially hydrolyzed milk-based formula, 60:40 whey-to-casein ratio, 50% lactose, and a blend of two prebiotics--galacto-oligosaccharide (GOS) and polydextrose (PDX)</td>
</tr>
<tr>
<td><em>Enfamil A.R.</em></td>
<td>thickened milk-based formula, 20:80 whey-to-casein ratio</td>
</tr>
<tr>
<td><em>Gerber Good Start Soy</em></td>
<td>partially hydrolyzed soy-based formula</td>
</tr>
</tbody>
</table>

For ages 9 months and older, the following contract formulas are also available:

<table>
<thead>
<tr>
<th>Formula</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Enfagrow Toddler Transitions</em></td>
<td>milk-based formula, 20:80 whey-to-casein ratio</td>
</tr>
<tr>
<td><em>Enfagrow Toddler Transitions Gentlease</em></td>
<td>partially hydrolyzed milk-based formula, 60:40 whey-to-casein ratio, 25% lactose</td>
</tr>
<tr>
<td><em>Gerber Graduates Soy</em></td>
<td>partially hydrolyzed soy-based formula</td>
</tr>
</tbody>
</table>

This form must be completed with a qualifying medical condition for infants to receive a formula other than a contract formula OR for children 12 months and older or women to receive either a contract formula or another formula.

**WIC Program Policy for Formulas Other than the Contract Formulas**

- By completing this form, you are indicating that a diagnosed qualifying medical condition necessitates the use of a different formula(s) from the current contract formulas. The local WIC clinic cannot consider the requested formula(s) without all of the required information.
- Substitution of another formula will only be considered if it meets the qualifying medical conditions as described below.
- Requests are limited to 6 months. It is our policy to re-evaluate the client's continued need for the formula(s) on a periodic basis during the requested time period.
- In some cases, incomplete or limited medical information may prevent the approval of the formula(s) requested. In order to expedite the approval process, WIC staff may need to contact the health care provider who requested the formula(s) to obtain more detailed medical information. Complete contact information is required on the front of the form.

**Qualifying Medical Conditions** – formula approvals will be considered for one or more of these reasons:

- Premature birth will be considered a qualifying medical condition for infants under 12 months of age to receive a premature formula.
- Low birth weight will be considered a qualifying medical condition for infants under 6 months of age to receive a high calorie formula.
- Inborn errors of metabolism and metabolic disorders.
- Must specify gastrointestinal disorder or malabsorption syndrome that impairs ingestion, digestion, absorption, or utilization of nutrients that could adversely affect nutritional status.
- GER or GERD only with an additional qualifying medical condition.
- Immune system disorders.
- Must specify life threatening disorders, diseases, or conditions.
- An extensively hydrolyzed formula or amino acid based formula can be provided for a diagnosed formula intolerance or food allergy to lactose, sucrose, milk protein, or soy protein.
- Failure to Thrive only when child is documented with one or more of the following: at or below 5th percentile weight-for-length on WHO growth charts for ages under 24 months OR at or below 5th percentile BMI-for-age on CDC Growth Charts for ages 24 months and older OR has dropped one growth channel in a 6-month time period which results in the child being below the 25th percentile weight-for-length or BMI-for-age. Current anthropometric data required.

**Non-qualifying Conditions** – formulas will not be approved solely for one or more of these reasons:

- Colic, spitting up, gassiness, or fussiness.
- Diarrhea, vomiting, or constipation that is of short duration or intermittent.
- Feeding difficulty without giving medical diagnosis.
- Medically necessary without giving medical diagnosis.
- Participant preference.
- Enhancing nutrient intake or managing body weight.
- Non-specific formula or food intolerance.

A standard milk-based or soy-based infant formula (other than the WIC contract formulas listed above) cannot be provided to a WIC participant for formula intolerance or food allergy to lactose, sucrose, milk protein, or soy protein.

No type of formula can be provided to a child or woman with lactose intolerance who is able to drink lactose-free milk.

If you have a question about a specific formula, please contact your local WIC office or the Florida WIC Program at 1-800-342-3556.

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.
Living Will

Declaration made this _____ day of ___________________ , 20_____ , I, _______________________________________, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_________ (initial) I have a terminal condition,
or __________ (initial) I have an end-stage condition,
or __________ (initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do _____ I do not _____ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name __________________________________________________________________________________________________________
Street Address __________________________________________________________________________________________________
City  _____________________________________________ State  ______________Phone  _____________________________________

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): ___________________________________________________________________________________ 
__________________________________________________________________________________________________________________

Signed ___________________________________________________________________  Date  __________________________________

Witness #1 _______________________________________________________________________________________________________
Street Address ____________________________________________________________________________________________________
City  _____________________________________________ State  ______________Phone  _____________________________________

Witness #2 _______________________________________________________________________________________________________
Street Address ____________________________________________________________________________________________________
City  _____________________________________________ State  ______________Phone  _____________________________________

At least one witness must not be a husband or wife or a blood relative of the principal.
Definitions for terms on the Living Will form:

“End-stage condition” means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

“Persistent vegetative state” means a permanent and irreversible condition of unconsciousness in which there is: The absence of voluntary action or cognitive behavior of any kind and an inability to communicate or interact purposefully with the environment.

“Terminal condition” means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

These definitions come from section 765.101 of the Florida Statues. The Statutes can be found in your local library or online at www.leg.state.fl.us.
Designation of Healthcare Surrogate

Name: ___________________________________________________________________________________________________________

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for healthcare decisions:

Name ____________________________________________________________________________________________________________
Street Address __________________________________________________________________________________________________
City ___________________________ State ___________ Phone ___________________________

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name ____________________________________________________________________________________________________________
Street Address __________________________________________________________________________________________________
City ___________________________ State ___________ Phone ___________________________

I fully understand that this designation will permit my designee to make healthcare decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of healthcare; and to authorize my admission to or transfer from a healthcare facility.

Additional instructions (optional): ___________________________________________________________________________________
__________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________

I further affirm that this designation is not being made as a condition of treatment or admission to a healthcare facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name: ____________________________________________________________________________________________________________
Name: ____________________________________________________________________________________________________________

Signed ___________________________ Date ___________________________

Witnesses:

1. ________________________________________________________________________________________________________________
2. ________________________________________________________________________________________________________________

At least one witness must not be a husband or wife or a blood relative of the principal.
intentionally left blank
Uniform Donor Form

You can use this form to indicate your choice to be an organ donor. Or you can designate it on your driver’s license or state identification card (at your nearest driver’s license office).

The undersigned hereby makes this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give:  
(a) ________ any needed organs or parts

(b) ________ only the following organs or parts for the purpose of transplantation, therapy, medical research, or education:
________________________________________________________________________________________________________
________________________________________________________________________________________________________

(c) ________ my body for anatomical study if needed. Limitations or special wishes, if any:
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Signed by the donor and the following witnesses in the presence of each other:

Donor’s Signature __________________________________________ Donor’s Date of Birth ______________________
Date Signed ____________________________ City and State __________________________________________________

Witness #1 ______________________________________________________________________________________
Street Address ______________________________________________________________________________________
City __________________________ State ______________ Phone __________________________

Witness #2 ______________________________________________________________________________________
Street Address ______________________________________________________________________________________
City __________________________ State ______________ Phone __________________________

You can use this form to indicate your choice to be an organ donor. Or you can designate it on your driver’s license or state identification card (at your nearest driver’s license office).
intentionally left blank
Healthcare Advance Directives

The card below may be used as a convenient method to inform others of your healthcare advance directives. Complete the card and cut it out. Place in your wallet or purse. You can also make copies and place another one on your refrigerator, in your car glove compartment, or other easy to find place.

Healthcare Advance Directives

I, ________________________________________
have created the following Advance Directives:
  ○ Living Will
  ○ Healthcare Surrogate Designation
  ○ Anatomical Donation
  ○ Other (specify) __________________________

Contact Information:

Name ________________________________________
Address ________________________________________
Phone ________________________________________
Signature _______________________________________
Date _________________________________________

FOLD