

Sponsored by
Coventry Health Care of Florida, Inc.
d/b/a Buena Vista

GENERAL INFORMATION

This handbook may be available in other formats such as Spanish and Braille. For more information, call our Customer Service Department toll free at 1-800-441-5501.

The Health Plan provides different types of communication for the hearing and visually impaired and for members that speak other languages free of charge. To find out more about these services please call our Customer Service Department toll free at 1-800-441-5501.

If you are hearing impaired, call 7-1-1 Relay

Este libro esta disponible en Español y Braille.
Para recibirlo, llame gratis al 1-800-441-5501.

For information about our performance and financial information, go to www.myvistamedicaid.com.

For information about our structure and operation, go to www.floridahealthstat.com.

To change your address, call the Department of Children and Families at 1-866-762-2237 or go to <http://www.myflorida.com/accessflorida/>.

HOURS OF OPERATION

CUSTOMER SERVICE

Customer Service	Monday-Friday 8:00 am - 7:00 pm
Pharmacy	Monday-Friday 8:00 am - 7:00 pm

ROUTINE HEALTH CARE

Doctors	By Appointment - hours vary
Specialists	With a "Referral" - by appointment - hours vary

AFTER HOURS

For care, call your doctor

For emergencies:	Go to an urgent care center for minor problems Go to a hospital or call 911 for serious problems
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For questions, call our Customer Service Department and leave a message

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WELCOME TO BUENA VISTA

Quality health care at your fingertips!

BECOMING A MEMBER

To join our plan, you must have Medicaid. Please call Medicaid Options at 1-888-367-6554. Membership begins on the first day of any calendar month.

If you don't pick a plan, the State will pick one for you.

ALL NEW MEMBERS

In order to get the best care, fill out the **Medical Release Form** and the **Health Risk Assessment Form** in this packet and send them back to us.

OPEN ENROLLMENT

You can join a plan when you first get Medicaid. There are also 60 days each year when you can change plans.

For more information, call your local Medicaid office.

Broward

1-866-867-0729 or 954-357-8494

Miami-Dade

1-800-953-0555 or 305-593-3000

Gadsden, Jefferson, Leon, Liberty, Madison, Taylor and Wakulla

1-800-248-2243 or 850-921-8474

Enrollment:

If you are a mandatory enrollee required to enroll in a plan, once you are enrolled in Buena Vista or the state enrolls you in a health plan, you will have 90 days from the date of your first enrollment to try the plan. During the first 90 days you can change health plans for any reason. After the 90 days, if you are still eligible for Medicaid, you will be enrolled in the plan for the next nine months. This is called "lock-in."

Open Enrollment:

If you are a mandatory enrollee, the state will send you a letter 60 days before the end of your enrollment year telling you that you can change plans if you want to. This is called "open enrollment." You do not have to change plans. If you choose to change plans during open enrollment, you will begin in the new plan at the end of your current enrollment year. Whether you pick a new plan or stay in the same plan, you will be locked into that plan for the next 12 months. Every year you can change health plans during your 60-day open enrollment period.

DISENROLLMENT

How do I change plans?

You can change plans for any reason during:

- Your initial 90-day enrollment period
- Your 60-day annual open enrollment period

Some people can join a plan at any time. They are:

- SSI recipients under the age of 19
- Foster care children
- Children in subsidized adoption arrangements
- Children enrolled in CMS
- American Indians

If you are a mandatory enrollee and you want to change plans after the initial 90-day period ends or after your open enrollment period ends, you must have a state-approved good cause reason to change plans. The following are state-approved cause reasons to change health plans:

- (1) The enrollee moves out of the county, or the enrollee's address is incorrect and the enrollee does not live in a county where the plan is authorized to provide services.
- (2) The provider is no longer with the health plan.
- (3) The enrollee is excluded from enrollment.
- (4) A substantiated marketing or community outreach violation has occurred.
- (5) The enrollee is prevented from participating in the development of his/her treatment plan.
- (6) The enrollee has an active relationship with a provider who is not on the health plan's panel, but is on the panel of another health plan.
- (7) The enrollee is in the wrong health plan as determined by the Agency.
- (8) The health plan no longer participates in the county.
- (9) The state has imposed intermediate sanctions upon the health plan, as specified in 42 CFR 438.702(a)(3).
- (10) The enrollee needs related services to be performed concurrently, but not all related services are available within the health plan network or the enrollee's PCP has

determined that receiving the services separately would subject the enrollee to unnecessary risk.

- (11) The health plan does not, because of moral or religious objections, cover the service the enrollee seeks.
- (12) The enrollee missed open enrollment due to a temporary loss of eligibility, defined as 60 days or less for non-Reform populations and 180 days or less for Reform populations.
- (13) Other reasons per 42 CFR 438.56(d)(2), including, but not limited to, poor quality of care; lack of access to services covered under the contract; inordinate or inappropriate changes of PCPs; service access impairments due to significant changes in the geographic location of services; lack of access to providers experienced in dealing with the enrollee's health care needs; or fraudulent enrollment.
- (14) Voluntary enrollees may disenroll from the health plan at any time.

Some Medicaid recipients can change health plans whenever they choose, for any reason. For example, people who are eligible for both Medicaid and Medicare benefits and children who receive SSI benefits can change plans at any time for any reason. To find out if you can change plans, call Medicaid Options at 1-888-367-6554.

If you have any problems, please call our Customer Service Department. You can change plans by calling Medicaid Options at 1-888-367-6554.

Will I be able to enroll again if I change plans?

Yes, call Medicaid Options at 1-888-367-6554.

Can the Plan disenroll me?

Yes, if you:

- Lose Medicaid
- Move out of the service area
- Let someone else use your ID card
- Let someone else use your Florida Medicaid Gold Card
- Are admitted to a long term care facility, hospice, or correctional facility
- Don't follow the recommended plan of care
- Miss 3 appointments in a row in a 6-month period
- Die
- Enroll in another plan

Can I still be a member if I don't have Medicaid?

No. If you don't have Medicaid, you can't enroll.

REINSTATEMENT PROCESS

What happens if I lose Medicaid?

If you lose Medicaid and get it again within sixty (60) days, you will automatically be reinstated to our Plan. If you need help re-enrolling, call Medicaid Options at 1-888-367-6554. We will tell you in writing when you are reinstated.

We will give you the same doctor unless:

- The doctor is no longer available
- You live in a different area
- You ask for another doctor

YOUR MEMBER ID CARD

You will get an ID card in the mail. You will need to show it to get health care. Your card has important information it. Keep it with you at all times.

When you go to a doctor, hospital or pharmacy, you will need your card. Never let anyone else use it. If you lose your card, call our Customer Service Department.

WHAT IF I WAS ASSIGNED BY THE STATE MEDICAID PROGRAM?

If you don't pick a plan, the state will pick one for you. If they pick us, we will assign you to a doctor near your home. If you want a different doctor, call our Customer Service Department. You may choose to have all family members served by the same doctor or you may choose different doctors. You can change your doctor at any time.

HOW TO GET CARE/COST SHARING

Your care is provided by doctors, hospitals and other health care workers. We must approve all of your care. We will pay for the care if it's approved. If it's not approved, you may have to pay for it.

QUALITY PERFORMANCE INDICATORS

You can ask for information about our plan's quality performance indicators. Call our Customer Service Department.

WHICH DOCTOR SHOULD I GO TO?

The name and phone number of your doctor is on your ID card. Your doctor will help you with all of your health care. You must use doctors in the health plan's network. Any services provided by a doctor that is not in the health plan's network must be approved by the health plan before you get the services. You may call customer service to request authorization to use a doctor that is not in the health plan's network. A list of the doctors in the health plan's network may be found in the Provider Directory.

For some care, your doctor will send you to a specialist. You must use our doctors except in an emergency.

If you want to change your doctor, call our Customer Service Department or go to our website, www.myvistamedicaid.com. You may request to change your PCP at any time. Our on-line Provider Directory is updated at least monthly.

Some doctors can't perform some services because of religious or moral beliefs. If there's a change in the doctor's services based on moral or religious beliefs, we will tell you within 90 calendar days after the change. For counseling or services that we don't cover because of moral or religious views, we don't need to provide information on how and where to get it.

WHAT IF I NEED TO SEE A SPECIALIST?

For some care, you may need to get a "Referral" from your doctor. If you don't get a referral and you see a doctor that is not in our network, you will have to pay for the visit.

HOW WILL THE DOCTOR KNOW WHAT CARE I HAVE?

We will tell your doctor that you are a member. When you go to the doctor, show your card. Your name, your doctor's name and your doctor's phone number are on the card.

GETTING APPROVAL FOR SERVICES

Your doctor will call the health plan to get approval for some services. Your doctor will let you know which services need to be approved by the health plan before you received them. You do not have to get approval from the health plan for emergency services or post-stabilization services.

WHEN CAN I SEE THE DOCTOR?

You can see your doctor right away. Call to make an appointment. The phone number is on your card. Call if you need to cancel the appointment.

If your doctor leaves our plan, you can get care from the doctor for up to 6 months if you are in an active course of treatment that is medically necessary.

If you are pregnant, you can stay with your doctor until you have the baby.

WHAT IF I HAVE AN EMERGENCY?

Call your doctor or go to an urgent care center for minor problems. Go to a hospital or **call 911** for emergencies. Call your doctor and us if you go to the hospital. You do not have to get prior authorization from the health plan for emergency or post-stabilization services.

WHAT IF I AM OUTSIDE THE SERVICE AREA?

Go to the hospital. Call your doctor and us as soon as you can.

WHAT IF I AM PREGNANT?

If you are pregnant or think you are pregnant, call your doctor.

NEWBORN ENROLLMENT

You must enroll the baby with the Florida Department of Children and Families Services before it's born to make sure it has Medicaid. Also, call our Customer Service Department.

You can pick a doctor for the baby as soon as you become pregnant or we can pick one for you. The Florida Department of Children and Families Services will give us your baby's Medicaid number.

We will cover your baby's health care for 3 months after it's born unless:

- You disenroll your baby
- Your baby loses Medicaid
- Your baby is enrolled in the Children's Medical Services Program

You must enroll your baby with us by 4 months of age to get care.

SECOND OPINION

If you want a second medical opinion about your health care, call your doctor and request one. Your doctor will review your second medical opinion and decide on a treatment plan that is best for you. If you choose one of our doctors, we will pay for the second medical opinion. If you choose a doctor that is not ours, you may have to pay all or part of the cost.

PROTECTED HEALTH INFORMATION

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we have procedures to keep your protected health information (PHI) safe. Your name, address, telephone, social security, and date of birth won't be given to anyone unless necessary for your health or if required by state or federal law. If we need to give out your information, we will code it to keep it safe.

You can let others see your health records by completing a HIPAA Authorization for Release of Protected Health Information Form. Call our Customer Service Department for more information.

BENEFITS

AMBULANCE SERVICES

You can get emergency transportation to hospitals.

BEHAVIORAL HEALTH CARE

HomeSafeNet (HSN)/Florida Safe Families Network

Children enrolled in the HomeSafeNet/Florida Safe Families Network program will have all behavioral health care services covered directly through Florida Medicaid or Child Welfare Prepaid Mental Health Plans. These services include inpatient, outpatient psychiatric, community mental health, and case management services.

For all other members, care is offered through PsychCare. Community doctors will see you on an outpatient basis or will provide inpatient care at hospitals listed in the directory. We can provide you with the names of doctors and can help you make an appointment. Call our Customer Service Department.

If you are not happy with the doctor or case manager assigned to you, you can ask to see another one. Call our Customer Service Department for assistance.

For emergencies in and out of the service area or diagnosis, call PsychCare at 1-800-221-5487.

The following feelings can indicate you need help:

- Sadness that won't go away
- Feelings of hopelessness or helplessness
- Feelings of guilt or worthlessness
- Trouble sleeping
- Poor appetite or weight loss
- Loss of interest in things you enjoy
- Trouble concentrating
- Irritability
- Headaches, stomach aches or backaches that won't go away

If you need help, call your doctor. You can get help 24 hours a day. If your doctor is not available, we will find another doctor for you. If you are in danger of hurting yourself or someone else, **call 911** or have someone take you to the nearest emergency room.

Covered Care Summary

COMMUNITY MENTAL HEALTH CARE	LIMITATIONS
Assessments:	
Psychiatric Evaluations	2 visits per year.
Brief Behavioral Health Status Evaluation	2 1/2 hours of evaluation per year.
Psychiatric Review of Records	2 reviews per year.
In-Depth Assessment	1 assessment per year.
Bio-psychosocial Evaluation	1 evaluation per year.
Psychological Testing	40 quarter-hour units per year.
Limited Functional Assessment	3 limited assessments per year.
Treatment Plan Development	1 per year.
Health and Psychiatric Care:	
Medication Management	Must meet your health needs.

Brief Individual Medical Psychotherapy	16 quarter-hour units per year.
Group Medical Therapy	18 quarter-hour units per year.
Behavioral Health Screening Care	2 screenings per year.
Behavioral Health Care	2 screenings per year.
Methadone or Buprenorphine Administration	52 times per year.
Behavioral Health Therapy:	
Individual and Family	104 quarter-hour units per year.
Group Therapy	156 quarter-hour units per year.
Behavioral Health Day Care	190 hour units per year.
Community Support and Rehabilitative Care:	
Psychosocial Rehabilitative Care Clubhouse Care	1,920 quarter-hour units combined for both.
Therapeutic Behavioral On-Site Care for Children and Adolescents:	
Therapeutic Care	36 quarter-hour units per month.
Behavior Management	36 quarter-hour units per month.
Therapeutic Support	128 quarter-hour units per month.
Hospital Care: Emergency Room Inpatient	Emergent care only. 45 day limit – Adults Children/Adolescents up to 365 days a year.
Case Management:	
Targeted Case Management	344 quarter-hour units per month.
Intensive Case Management (Team)	48 quarter-hour units per month.

CIRCUMCISION

Available up to 12 weeks of age.

DENTAL

Children under age 21 in Miami-Dade County should call Dental Quest (ADI) at 1-800-964-7811.

Children under age 21 in other counties, call your local Medicaid office:

Broward	1-866-867-0729 or 954-357-8494
Gadsden, Jefferson, Leon, Liberty, Madison and Wakulla	1-800-248-2243 or 850-921-8474

DOCTOR VISITS

Your doctor manages all of your health care needs. We will pay for your visits to doctors in our network.

EMERGENCY CARE

A doctor can be called 24 hours a day. If you need emergency care, go to an urgent care center or hospital or **call 911**.

FAMILY PLANNING

You can go to family planning classes or get materials. Ask your doctor for more information. You may obtain family planning services from any participating Medicaid doctor without prior authorization.

HEALTH SCREENINGS

You will receive a schedule for check-ups and shots. You can get health screenings through your doctor. Please get the health screenings you need within the 90 days of becoming a member. If more testing is needed, your doctor will tell you.

See the Preventive Care Guidelines for more information.

HEARING

You can get medically necessary hearing evaluations and diagnostic testing every 3 years. Care is provided as stated in the Medicaid Hearing Services Coverage and Limitations Handbook.

HOME HEALTH CARE AND MEDICAL EQUIPMENT

You can get home health care and medical equipment if your doctor orders it.

HOSPITAL CARE

We cover inpatient hospital services including medical supplies, diagnostic tests, therapeutic services and all supplies and equipment to provide the appropriated treatment of patients.

NOTE:

For recipients age 21 and older, inpatient hospital services are limited to 45 days.

For recipients under the age of 21, there is no limit. The health plan will cover 45 days of inpatient hospital services during each state fiscal year. The state will cover inpatient hospital services after 45 days.

OUTPATIENT CARE

We cover outpatient hospital services including medical supplies, nursing care, therapeutics services and drugs. Some outpatient hospital services are limited to \$1,500 for adults age 21 and older. There is no limitation for children 20 years of age or younger.

LABORATORY AND X-RAYS

Your doctor will tell you if you need these services. Some care may require a referral.

POST-STABILIZATION CARE

You can get post-stabilization care within or outside the plan network if:

- We pre-approved it
- We did not respond to the doctor's request within 1 hour after it was made
- We could not be contacted for approval
- The care followed an emergency and was medically necessary

PRESCRIPTION DRUGS

You can get medicine (including unlimited generic drugs) at area drug stores and supermarkets. If you are outside the area and have to pay for medicine, we will pay you back.

SPECIALTY CARE

Talk to your doctor if you or your child needs special care. Some care may require a referral.

THERAPY

Children under the age of 21 can get physical, speech, occupational or respiratory therapy. Adults can get physical or respiratory therapy.

TRANSPORTATION

As of March 1, 2008, the State of Florida Medicaid Program will give you rides to your doctor's office. Call the phone number for the transportation service in your county:

Broward	1-866-867-0729
Gadsden	(850) 627-9958
Jefferson	(850) 997-1323
Liberty	(850) 643-2524
Madison	(850) 973-4418
Miami-Dade	1-866-726-1457 or 1-866-726-1458
Taylor	(850) 838-3553

If you have any questions, call our Customer Service Department. For emergencies, call **911**

VISION

You can get Medicaid-approved eye exams, eyeglasses and medically necessary contact lenses as stated in the Florida Medicaid Summary of Services at:

http://ahca.myflorida.com/Medicaid/pdf/files/SS_10_100501_SOS_ver2.4_1164_1011_FINAL2.pdf.

To find out about benefits that are not covered by this health plan but are covered by the Medicaid State Plan please contact your local Medicaid office at 1-866-875-9131 in Broward County, 1-800-953-0555 in Miami-Dade County, or 1-800-248-2243 in Tallahassee.

QUALITY BENEFIT ENHANCEMENTS

To learn more about these programs, call your doctor or our Customer Service Department.

STOP SMOKING – “COMMITTED QUITTERS PROGRAM”

SUBSTANCE ABUSE

DOMESTIC VIOLENCE

PREGNANCY PROGRAMS – PRE/POST

CHILDREN'S PROGRAMS

HELP THEM THRIVE, BIRTH TO FIVE – NUTRITION/BREASTFEEDING

Call WIC at 1-800-342-3556.

HEALTH SCREENINGS, PREVENTION AND EARLY INTERVENTION

May include:

- medical history
- physical exam
- nutritional assessment
- developmental assessment
- updating of routine immunizations
- laboratory tests (including blood lead screening)
- vision, hearing, and dental screenings*
- health education, diagnosis and treatment
- referral and follow up as appropriate

*Vision and hearing screening are provided according to an established periodicity schedule. A dental screening referral is provided for recipients beginning at age three, or earlier if indicated.

DISEASE MANAGEMENT

For chronic health conditions

GRIEVANCE & APPEALS PROCESS

A **grievance** is a formal complaint about a doctor or service. An **appeal** is a formal complaint about a service that is denied.

A **grievance** may be filed orally or in writing within one year of the incident.

An **appeal** may be filed orally or in writing within thirty (30) days of receiving the notice of action. If the appeal is filed orally (except for an expedited appeal), it must be followed up with a written notice within ten (10) days.

Call 1-800-441-5501, Monday – Friday, 8:00 am - 6:00 pm. TTY 7-1-1 Relay

Write Grievance & Appeals Dept., 1340 Concord Terrace, Sunrise, FL 33323

NOTE: If you call, you still need to send a written request within 30 days.

We can assist you with the filing of a grievance or appeal or a doctor can file for you. No action will be taken against the doctor. During the process, you can examine your health records and other documents.

Once you have filed, you are not required to follow up. Care will continue at no cost. However, if the final decision is not in your favor, you may have to pay for care.

We will resolve your grievance and provide notice of our decision within 30 days. We will resolve your appeal and provide notice of our decision within 45 days. If more time or more information is needed, we will let you know.

SUBSCRIBER ASSISTANCE/MEDICAID FAIR HEARING:

If you don't agree with the decision, you or your doctor can:

-Ask for a review by the Subscriber Assistance Program (within 1 year after the date of the occurrence that initiated the appeal)

Agency for Health Care Administration
Subscriber Assistance Program/Beneficiary Assistance Program
Building 1, MS #26
2727 Mahan Drive
Tallahassee, Florida 32308
(850) 412-4502

- Ask for a Medicaid Fair Hearing (within 90 days)

Office of Public Assistance Appeals Hearings
1317 Winewood Boulevard
Building 5, Room 203
Tallahassee, FL 32399-0700
1-850-488-1429

NOTE: If you ask for a Medicaid Fair Hearing, you give up the right to Subscriber Assistance.

Care will continue at no cost. However, if the final decision is not in your favor, you may have to pay for care.

QUICK REVIEW:

A quick review is necessary when your life or health status is in danger. You or your doctor can file a quick review either verbally or in writing. We will make a decision within 72 hours or sooner as the health condition requires. We can also help you with the filing of a quick review.

For more information:

Call 1-800-441-5501, Monday - Friday from 8:00 am - 6:00 pm, TDD 7-1-1 Relay

Write Grievance & Appeals Dept., 1340 Concord Terrace, Sunrise, FL 33323

LIVING WILL AND ADVANCE DIRECTIVES

What should I know about a Living Will?

Living Wills and Advanced Directives let you have your wish about life support. If you are seriously ill and can't speak for yourself, you can pick someone to speak for you. Ask your doctor for more information. If you make a Living Will, give a copy of it to your doctor.

You have the right to direct your care by giving your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called advance directives. Written information about advance directives are available for members upon request by calling customer service. If there are any changes in the state law, we will tell you as soon as possible, but no later than 90 calendar days after the effective change.

It is your choice whether you want to fill out an advance directive. According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with the Agency for Health Care Administration (AHCA) by calling 1-888-419-3456 between the hours of 8:00 a.m. to 6:00 p.m., Monday through Friday.

MEMBER RIGHTS & RESPONSIBILITIES

We have adopted the Florida Member's Bill of Rights and Responsibilities. You can request a copy of it from your doctor.

RIGHTS

You have the right to have your privacy protected

You have the right to a response to questions and requests

You have the right to know who is providing services to you

You have the right to know the services that are available, including an interpreter if you don't speak English

You have the right to know the rules and regulations about your conduct

You have the right to be given information about your health

You have the right to get service from out-of-network providers

You have the right to get family planning services from any participating Medicaid provider without prior authorization

You have the right to be given information and counseling on the financial resources for your care

You have the right to know if the provider or facility accepts the assignment rate

You have the right to receive an estimate of charges for your care

You have the right to receive a bill and to have the charges explained

You have the right to be treated regardless of race, national origin, religion, handicap, or source of payment

You have the right to be treated in an emergency

You have the right to participate in experimental research

You have the right to file a grievance if you think your rights have been violated

You have the right to information about our doctors

You have the right to be treated with respect and with due consideration for your dignity and privacy

You have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand

You have the right to participate in decisions regarding your health care, including the right to refuse treatment

You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation

You have the right to request and receive a copy of your medical records and request that they be amended or corrected

You have the right to be furnished health care services in accordance with federal and state regulations

You are free to exercise your rights, and the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat you

RESPONSIBILITIES

You should provide accurate and complete information about your health

You should report unexpected changes in your condition

You should report that you understand your care and what is expected of you

You should follow the treatment plan recommended

You should keep appointments

You should follow your doctor's instructions

You should make sure your health care bills are paid

You should follow health care facility rules and regulations

FRAUD, ABUSE & OVERPAYMENT

If you suspect fraud, abuse, or overpayment, call our Customer Service Department. We will document the information and tell our Internal Audit and Fraud Prevention Department. You may also report suspected fraud, abuse, or overpayment by calling the Florida Medicaid Consumer Complaint Hotline toll-free at 1-888-419-3456 or by completing a Medicaid Fraud and Abuse Complaint Form, which may be found online at https://apps.ahca.myflorida.com/inspectorgeneral/fraud_complaintform.aspx

IMPORTANT REMINDERS

Call your doctor before getting care

In an emergency, go to the nearest hospital or **call 911**. Call your doctor and us as soon as possible

Keep your ID card and Florida Medicaid Gold Card with you at all times

Call to cancel an appointment with your doctor if you are unable to go

Call Customer Service at 1-800-441-5501 for questions about your care

Call Pharmacy Customer Service at 1-866-847-8279 for questions about drug coverage

Answer all of the questions and sign all of the forms that need to be completed

For drug coverage problems, call our Medicaid Ombudsman/Hernandez Ombudsman at 1-888-853-2636, Monday - Friday from 8:00 am to 7:00 pm

Call your Florida Department of Children and Families Case Worker if you are moving to another county or state

Call our Customer Service Department if you need help changing your membership information or want to change your doctor

If you have any questions, call our Customer Service Department.

Thank you for choosing us for your health care needs. We look forward to hearing from you!

Coventry Health Care of Florida, Inc.

d/b/a Buena Vista

1340 Concord Terrace

Sunrise, FL 33323