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**Verify Eligibility**

A member's eligibility status can change at any time. Therefore, at the initial visit, Primary Care Physicians (PCPs) should request a copy of the member's identification card along with additional proof of identification, such as a photo ID, and file them in the medical record. Eligibility should be verified at each subsequent visit.

Specialty care physicians, hospitals, and ancillary service providers should also request to see the member's identification card to verify current eligibility.

PCPs may also refer to their current monthly membership listing. If a member does not appear on the list, please verify membership by:

- accessing the Plan Web site at [www.wellcare.com](http://www.wellcare.com);
- using our Interactive Voice Response (IVR) system;
- schedule an in-service to introduce the features of the Web site to your staff by contacting your Provider Relations Representative.

**Verification is based on the data available at the time of the request, by any means, and since subsequent changes in eligibility may not yet be available, verification of eligibility is never a guarantee of coverage.**

**Member Identification Cards**

The purpose of the member identification card is to identify plan members and facilitate their interactions with physicians and other health care providers. Information found on the member identification card will include the member's name, identification number, Primary Care Physician's name and telephone number, co-payment information, health plan contact information and claims filing address. Possession of the member identification card does not guarantee eligibility or coverage. The physician or provider is responsible for ascertaining the current eligibility of the

cardholder. When appropriate, the Customer Service Department should be contacted in order to verify all applicable co-payment, or coinsurance requirements.

**Enrollment**

Membership enrollments may be voluntary or by state-mandated assignment.

Membership acceptance must be without consideration of the applicant's health condition.

Membership acceptance must be without regard to color, gender, race, religious belief, national origin, or disability of the applicant.

Members who have been disenrolled due to loss of Medicaid eligibility and are reinstated within three (3) months, will automatically be re-enrolled in the Plan when they regain eligibility.

All new members are provided a complete membership package containing the following:

- terms and conditions of enrollment.
- description of covered services.
- information about primary care physicians; such as location, telephone number, and office hours.
- information regarding "out-of-plan" emergency services.
- grievance and disenrollment procedures.
- all new members receive an in-service from a qualified benefit consultant.

**Assignment of Primary Care Physician**

Upon enrollment, the member will select a Primary Care Physician within the Plan's network. To ensure quality and continuity of care, the Primary Care Physician is responsible for managing all of the

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member's health needs from providing Primary Care Services, to coordinating referral to specialists and ancillary service providers.

At the start of each month, Primary Care Physicians are sent a list of members assigned to his or her panel.

**Changing Primary Care Physicians**

A member may change their Primary Care Physician by calling our Customer Service Department. Primary Care Physician changes that are requested between the 1<sup>st</sup> and the 10<sup>th</sup> day of the month can be made effective for the same month of eligibility. If the request is called in after the 10<sup>th</sup> of the month, the change will be effective for the following month of eligibility. If the member's health is at risk, an exception can be made to make the PCP change effective immediately.

**Voluntary Disenrollment**

Voluntary disenrollment may only occur during the first 90 days of membership; after one year in the Plan; or for an acceptable "Good Cause" reason. A member cannot be disenrolled as the result of a pre-existing medical condition or a change in the member's health status.

**Involuntary Disenrollment**

A member may be involuntarily disenrolled for the following reasons:

1. Member becomes deceased or moves out of the service area.
2. Member loses his/her Medicaid eligibility.
3. Member fraudulently uses his/her Medicaid card benefits.
4. Member is admitted into a long-term care facility or Hospice program.
5. Member is non-compliant with the rules of enrollment or is abusive to provider and/or Plan employees.