

## SECTION D ELIGIBILITY AND ENROLLMENT

### MEDICARE ELIGIBILITY

Generally, Medicare is available for people age 65 or older, people under age 65 with certain disabilities and people of all ages with End Stage Renal Disease (permanent kidney failure requiring dialysis or transplant). Medicare has Part A (Hospital Insurance), Part B (Medicare Insurance) and Part D (Prescription Drug Coverage).

Beneficiaries are eligible for premium-free Part A if you are age 65 or older and they or their spouse worked and paid Medicare taxes for at least 10 years. While most people do not have to pay a premium for Part A, everyone must pay for Part B if they want it. The monthly premium is deducted from their Social Security, Railroad Retirement, or Civil Service Retirement check. If the beneficiary does not get any of these payments, Medicare sends a bill for the premium every 3 months.

### SELECTING A PCP

A list of all PCPs is included in the Health Care Plan Consultant packets so Members may select their own PCP. A member must choose a PCP prior to enrollment.

### MEMBER ELIGIBILITY

To verify eligibility, the provider should always use the Automatic Voice Response System (AVRS), [www.abrazoadvantage.com](http://www.abrazoadvantage.com), or call Member Services at the time of service.


### MEMBER IDENTIFICATION CARDS

Each AAHP eligible Member is provided an AAHP identification card that shows the Member name and ID number. Sample AAHP identification cards have been included below. Services may not be denied if a Member does not have their ID card.

The Member's ID card should be presented to the provider when receiving services. However, the identification card does not guarantee that a Member is still eligible for benefits. If there are any questions regarding eligibility, please utilize the resources detailed above.

### **ABRAZO ADVANTAGE PLUS ID CARD**

All dually-enrolled members are instructed to carry both their Abrazo Advantage Plus Health Plan and AHCCCS identification cards. Please check for both cards.

<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <b>Abrazo Advantage Health Plan</b> <i>Plan on more.</i></div> <table style="width: 100%; border: none;"><tr><td style="width: 50%;">Policy # 00000</td><td style="width: 50%;">RxBin 003858</td></tr><tr><td>Issuer 80840</td><td>RxPCN A4</td></tr><tr><td>ID M2000XXXX</td><td>RxGRP PH7A</td></tr><tr><td>Name XXXX X XXXX</td><td>RxD M2000XXXX</td></tr></table> <p>Office Visits-PCP \$0/Specialist \$0 Pharmacy: \$1 or \$2.15 for Generic/OTC (including brand drugs treated as Generic) \$3.10 to \$5.35 for brand drugs ER: \$0-Hospital \$0 Abrazo Advantage Plus CMS H5985 002</p>	Policy # 00000	RxBin 003858	Issuer 80840	RxPCN A4	ID M2000XXXX	RxGRP PH7A	Name XXXX X XXXX	RxD M2000XXXX	<p>Submit Claims to:</p> <table style="width: 100%; border: none;"><tr><td style="width: 50%; vertical-align: top;">Abrazo Advantage Health Plan P.O. Box 833898 Richardson, TX 75083-3898 602-824-3900 or 1-888-864-1114</td><td style="width: 50%; vertical-align: top;">Customer Service/24Hr. Medical Advice 602-824-3900 or 1-888-864-1114 TTY/TDD 1-800-489-1473</td></tr></table> <p>If found please mail to: Abrazo Advantage Health Plan 7878 N. 16<sup>th</sup> Street #105 Phoenix, AZ 85020</p> <p>Medicare Contact Information 1-800-MEDICARE (1-800-633-4227) TTY/TDD users 1-877-486-2048</p> <p style="text-align: center;"><a href="http://www.Abrazoadvantage.com">www.Abrazoadvantage.com</a></p>	Abrazo Advantage Health Plan P.O. Box 833898 Richardson, TX 75083-3898 602-824-3900 or 1-888-864-1114	Customer Service/24Hr. Medical Advice 602-824-3900 or 1-888-864-1114 TTY/TDD 1-800-489-1473
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as a means of coercion, discipline, convenience, or retaliation.

### **MEMBER APPEALS, RECONSIDERATION AND GRIEVANCE**

An Appeal means any of the procedures that deal with the review of adverse organization determinations for health care services a Member believes they are entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member).

#### **Reconsideration**

A Reconsideration means the first step in the appeal process; AAHP or the independent review entity (IRE) may reevaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

A Reconsideration of an organization determination must be filed with sixty (60) calendar days from the date of the notice of AAHP's determination. If there is good cause, AAHP may extend the time frame for filing a request for reconsideration. Good cause may include, but not be limited to:

- The Member did not personally receive the adverse organization determination notice or it was late.
- The Member was seriously ill, which prevented a timely appeal.
- There was a death or serious illness in the Member's immediate family.
- An accident caused important records to be destroyed.
- Documentation was difficult to locate within the time limits.
- The enrollee had incorrect or incomplete information concerning the reconsideration process; or
- The Member lacked capacity to understand the time frame for filing a request for reconsideration.

AAHP will notify the Member of the Reconsideration decision as expeditiously as the Member's health condition requires, but no later than thirty (30) calendar days after receipt of the Appeal.

AAHP also may extend this timeframe up to fourteen (14) calendar days if the Member requests an extension, or if AAHP can justify a need for additional information and documents how the delay is in the interest of the Member.

If AAHP makes a Reconsideration determination that affirms (in whole or in part) its adverse organization determination, we will prepare a written explanation and send the complete case file to the Center for Health Dispute Resolution (CHDR) contracted by CMS. This will be completed as expeditiously as the Member's health condition requires, but no later than thirty (30) calendar days from the date AAHP receives the request for a standard reconsideration, or no later than the end of any extension.

If AAHP overturns the original adverse organization determination (in whole or in part) AAHP will notify the Member and order payment of the denied claim or authorization of the denied services. Services will be authorized or provided as expeditiously as the Member's health condition requires, but no later than thirty (30) calendar days (plus extensions) from the original request.

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### **Expedited Reconsideration**

Expedited Reconsideration means a reconsideration of a determination, in situations where applying the standard time frame could seriously jeopardize the Member's life, health, or ability to regain maximum function, including cases in which AAHP makes a less than fully favorable decision to the Member.

A physician may request that AAHP expedite a Reconsideration of a determination, in situations where applying standard time frame could seriously jeopardize the Member's life, health, or ability to regain maximum function, including cases in which AAHP makes a less than fully favorable decision to the Member.

A request for payment of service already provided to a Member is not eligible to be reviewed as an expedited reconsideration.

To ask for an Expedited Reconsideration, a Member or Physician must submit an oral or written request directly to AAHP. A physician may provide oral or written support for a request made by a Member of an Expedited Reconsideration.

A physician does not need to be an authorized representative to request an Expedited Reconsideration on behalf of a Member.

If the request is made or supported by a physician, AAHP will automatically grant the Expedited Reconsideration request when the physician indicates that the life or health of the Member, or the Member's ability to regain maximum function could be jeopardized by applying the standard time frame in the processing of the reconsideration request.

AAHP will automatically expedite all requests to appeal skilled nursing facility, home health, and Comprehensive Outpatient Rehabilitation Facility and physical therapy discontinuations and terminations.

If the request for an Expedited Reconsideration is denied, AAHP will automatically transfer the request to the Standard Reconsideration process: telephone the Member and give an oral notice of the denial of the request for reconsideration; and a description of the Member's rights. AAHP will mail to the Member within three (3) calendar days of the oral notification, a written letter explaining the standard reconsideration thirty (30) day time frame; the right to file an expedited grievance; the right to resubmit a request for an expedited reconsideration with any physician's support indicating that applying the standard time frame for making a determination could seriously jeopardize the Member's life, health or ability to regain maximum function. The request with any physician support will be expedited automatically and provide instruction about the grievance process and its time frames.

If the request for an Expedited Reconsideration is for a denied service, AAHP will notify the Member of the reconsideration decision as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after receipt of the request.

### **Member Grievance**

Grievance means any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which an organization or delegated entity provides health care services, regardless of whether any remedial action can be taken. A Member may make the complaint or dispute, either orally or in writing, to an organization, provider, or facility. A grievance may also include a complaint that an organization refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration timeframes.

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AAHP responds to a Member's expedited grievance within twenty-four (24) hours.

If a Member calls AAHP to file a grievance (complaint) regarding a provider, AAHP may ask for the provider's assistance in resolving the issue. When a Grievance Coordinator contacts an office to follow-up on a grievance, the intent is to clarify the situation, conduct fact-finding, and provide appropriate direction to the Member. It may also be necessary to educate the provider's office on Medicare and AAHP policies and procedures.

Member satisfaction relies upon the provider's cooperation with these activities. AAHP works in partnership with their contracted providers to maintain high Member satisfaction and retention.

### **MEMBER RESPONSIBILITIES**

As a member of AAHP, each Member has the following responsibilities:

- To get familiar with coverage and the rules you must follow as a Member.
- To give doctors and other providers the information needed to provide care, and to follow the treatment plans and instructions that are agreed upon.
- To act in a way that supports the care given to other patients and helps the smooth running of the doctor's office, hospitals, and other offices.
- To pay your plan premiums and any co-payments for the covered services.
- To advise of any questions, concerns, problems, or suggestions.

### **ADVANCED DIRECTIVES**

Members have the right to formulate advanced directives, which may include a Living Will or a Health Care Power of Attorney. Documentation is required in the medical record as to whether or not an adult member has completed Advanced Directive.

The Patient Self-Determination Act, passed by Congress in 1991, requires that health care providers educate patients on issues related to Advance Directives. The Act requires all Medicare and Medicaid providers to furnish timely information so patients have the opportunity to express their wishes regarding the refusal of medical care. PHP/CC and AAHP as well as AHCCCS and CMS must comply with this Act, and request your cooperation in helping us become compliant. Documentation is required in the medical record as to whether or not an adult member has completed an Advanced Directive.

Below are suggestions to assist in bringing your medical records into compliance with this standard:

1. Add a line to your initial patient assessment record stating
  - a. Advance Directive discussed - Yes or No
  - b. Do you have a Living Will or Power of Attorney - Yes or No
2. Stamp the front of the member's chart or provide a "sticker" on the chart with the above statements(s). Please be sure to address the above questions with the member. A number of providers have implemented the questions but they are left unanswered. If you would like more information on health care directives, you may contact the following organizations listed under the Advanced Directive Resource List in this section.

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### **Living Will**

A Living Will is a document that allows a Member to express what types of services they do or do not want should they become ill.

In order for the Living Will to be legal, the following conditions **MUST** be met:

- The Living Will must be signed and dated in front of two other people. The two other people must also sign the document.
- The witnesses must **NOT** be designated to make medical decisions for the member.
- The witnesses must **NOT** be directly involved in providing the member's health care.
- The witnesses must **NOT** be related to the member by blood, marriage, or adoption.
- The witnesses must **NOT** have a right to receive any part of the member's estate.

### **Health Care Power of Attorney**

Members have a right to be informed so that they understand and are able to make decisions about their health care. However, there may be a time when a Member is not able to make these decisions. A Health Care Power of Attorney allows a Member to choose another person to make decisions about the Member's health care if the Member is unable to make the decisions for themselves.

Health Care Power of Attorney **MUST** do the following:

- State the name of the individual the Member authorizes to make their medical decisions.
- State that the person named can only make health care decisions for a Member while the Member is unable to make or communicate health care decisions.
- Be dated and signed by the Member.
- Include signatures of witnesses or a Notary Public.

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### ADVANCE DIRECTIVES RESOURCE LIST

Organization:

Available Resource:

Aging and Adult Administration  
Arizona State Government  
1789 W. Jefferson  
Site Code 950A  
Phoenix, AZ 85007  
602.542.4446

Advanced directives forms and information

Arizona Hospital Association  
1501 W. Fountainhead Parkway  
Suite 650  
Tempe, AZ 85282

Advance directives forms and informational packets  
for hospitals

Arizona Medical Association  
810 W. Bethany Home Rd.  
Phoenix, AZ 85013  
602. 246.8901

Advance directives kits

Arizona Senior Citizens Law Project  
1818 S. 16th St.  
Phoenix, AZ 85034  
602. 252.-6710

Free legal assistance for senior citizens;  
house calls provided upon request

Dorothy Garske Center  
4250 E. Camelback Rd., #185K  
Phoenix, AZ 85018  
602. 952.1464

Advance directives forms and information