

CHANGES TO PROVIDER INFORMATION

Providers must notify 'Ohana of changes to the following information:

- Tax ID number
- Telephone and fax numbers
- Group name or affiliation
- Credentialing status
- Physical, mailing and billing addresses

The notification must be received, in writing, prior to the change. This notification should include a list of all network providers affected by the change. Site inspection evaluations of new office locations may be required.

PROVIDER MANUAL

For additional information on these and other topics, please refer to 'Ohana's Provider Manual. The manual should be used as a reference source that describes requirements and processes for administering our plan as outlined in our provider agreement. For a copy, visit www.ohanahealthplan.com or contact your local Provider Relations representative.

QUALITY IMPROVEMENT INITIATIVES

'Ohana providers are contractually obligated to participate in any quality improvement initiatives targeted at enhancing clinical outcomes or service delivery. Our Quality Improvement program is designed to actively initiate, monitor and evaluate standards of health care for our members, including programs for Case and Disease Management and Service Coordination for all members.

ADVANCE DIRECTIVES

All members 18 years and older should receive information concerning Advance Directives and the opportunity to sign an Advance Directive Acknowledgement form. Advance Directive forms should be made available in providers' offices. Discussion with the member should be documented in the medical record, and if the member chooses to sign a form, it should be included in his or her record. A provider shall not, as a condition of treatment, require a member to execute or waive an Advance Directive.

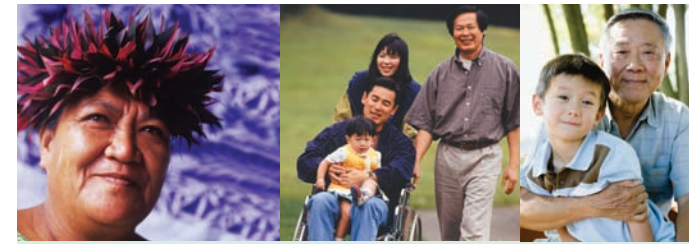


Toll-Free Telephone
Medicaid: 1-888-846-4262
Medicare: 1-888-505-1201
Web Site: www.ohanahealthplan.com

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.

HI07943_WCG_BRO_ENG

©WellCare 2008 HI_11_08



PROVIDER RESPONSIBILITIES



25069

‘OHANA PROVIDER RESPONSIBILITIES

‘Ohana Health Plan, a health plan offered by WellCare Health Insurance of Arizona, Inc., is a managed care organization (MCO) with local operations to serve individuals and families who are eligible for Medicaid and/or Medicare.

‘OHANA’S COMMITMENT TO PROVIDERS:

- Superior service to network physicians, hospitals and members;
- Designated staff to respond to your specific questions or inquiries; and
- Local Provider Relations representatives to foster relationships.

‘Ohana providers should accept all members for treatment and should not segregate members from other patients in any way. Members are to be provided services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, health status, income status or physical or mental disability.

Here are some highlights of your responsibilities as an ‘Ohana provider.

PRIMARY CARE PROVIDERS

Primary Care Providers (PCPs) provide comprehensive primary care services to our members. They coordinate, monitor and supervise the delivery of medical care with specialists, case managers and family members or legal custodians/guardians.

SPECIALISTS

Specialists are responsible for treating members referred by ‘Ohana PCPs and communicating with our Health Services and Pharmacy departments for authorizations.

PREVENTIVE HEALTH CARE VISITS

State and federal statutes mandate that certain preventive health services be provided to all eligible members, and our provider agreements require physician and provider compliance with these requirements. It is important for providers to reach out to members, encouraging them to make preventive health appointments.

Providers may use routine office visits to perform preventive services, ensuring that the office visit codes for the services provided are combined with the necessary ICD-9 modifying code when submitting claims and/or encounter data to ‘Ohana.

PROVIDER AVAILABILITY

Participating providers are expected to have services available to members 24 hours a day, seven days a week. After-hours care may be provided in one of three ways:

- 1) 24-hour answering service;
- 2) Answering system with an option to page the physician; or
- 3) Advice nurse with access to the treating or on-call physician.

APPOINTMENT SCHEDULING

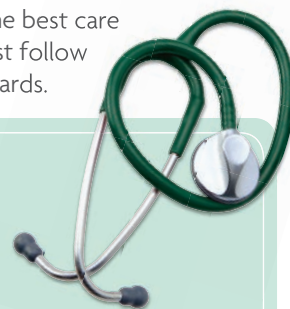
To help our members receive the best care possible, network providers must follow our access and availability standards.

PRIMARY CARE PROVIDERS MUST:

- Provide medical coverage 24 hours a day, seven days a week;
- See scheduled appointments within 30 minutes of the appointment time;
- Schedule and see emergent referral appointments immediately;
- Schedule and see urgent appointments within one day;
- Schedule and see non-urgent, but in need of attention, appointments within one week; and
- Schedule and see routine and preventive care appointments within one month.

SPECIALTY CARE PROVIDERS MUST:

- Schedule and see emergent referral appointments immediately;
- Schedule and see urgent referral appointments within one day;
- Schedule and see non-urgent, but in need of attention, appointments within one week; and
- Schedule and see routine and preventive care appointments within one month.



MEDICAL RECORDS

Each participating provider is responsible for confidentially maintaining a complete and accurate medical record for each Plan member. These records should reflect professional practice standards, as well as state, federal and accreditation requirements. Providers must make the medical records available for quality-care review studies by Plan reviewers, the United States Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), Plan members and organizations conducting accreditation audits, without charge.

AUDITS

As a part of regulatory and accreditation requirements, ‘Ohana may conduct periodic audits of provider availability, appointment scheduling and member medical records. Physicians and providers must provide access to the Plan or its designee to examine thoroughly the primary care offices, books, records and operations of any related organization or entity.

Audit criteria are based on regulatory requirements and accreditation guidelines set forth by CMS. Findings of deficiencies are shared with the providers.

CREDENTIALING

All providers must be credentialed by ‘Ohana or its designee prior to being designated as a participating provider. The baseline criteria for initial credentialing includes a current license to practice, board certification, hospital admitting privileges and professional liability insurance. PCPs in solo practice must have a participating covering physician willing to care for members in their absence.

After initial credentialing, providers must be re-credentialed every three years. The credentialing process includes site inspection evaluations for all PCPs, OB/GYNs, high-volume behavioral health providers and unaccredited facilities.

LIABILITY INSURANCE

Providers must meet professional liability insurance standard limits as outlined in the Provider Manual in order to meet the Plan’s credentialing requirements.

