9. HELP WITH PROBLEMS

At Health Partners, we work very hard to keep you healthy, and to make sure that you are happy with the services we provide. Sometimes, however, you may have a concern about your health care or Health Partners' services. We want to work out any concerns you have, and will work hard to resolve any problems you may have. Many times, our Member Relations department can help you with these questions or concerns. Health Partners Member Relations representatives are available around-the-clock, seven days a week, by calling 1-800-553-0784 or 215-849-9600, TTY 1-877-454-8477 or 215-849-1579.

Complaints, Grievances and Fair Hearings

If a provider or Health Partners does something that you are unhappy about or do not agree with, you can tell Health Partners or the Department of Public Welfare what you are unhappy about or that you disagree with what the provider or Health Partners has done. This section describes what you can do and what will happen.

Complaints

What is a complaint?

A complaint is when you tell us you are unhappy with Health Partners or your provider or do not agree with a decision by Health Partners.

Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that Health Partners has approved.

If you need more information about help during the complaint/grievance process, see page 39

What should I do if I have a complaint?

First Level Complaint

To file a complaint, you can:

- Call Health Partners at 1-800-553-0784 or 215-849-9600, TTY 1-877-454-8477 or 215-849-1579 and tell us your complaint.

Or

- Write down your complaint and send it to us at:

  Complaint & Grievance Dept.
  Health Partners
  901 Market Street, Suite 500
  Philadelphia, PA 19107

- Your provider can file a complaint for you if you give the provider your consent in writing to do so.

This is called a ***first level*** complaint.

When should I file a first level complaint?

You must file a complaint within **45 days of getting a letter** telling you that:

- Health Partners has decided that you cannot get a service or item you want because it is not a covered service or item.
- Health Partners will not pay a provider for a service or item you got.
- Health Partners did not decide a complaint or grievance you told us about before within 30 days.

You must file a complaint **within 45 days of the date you should have gotten a service or item** if you did not get a service or item. The time by which you should have received a service or item is listed on the chart on page 8.

You may file **all other complaints at any time.**

What happens after I file a first level complaint?

After you file your complaint, you will get a letter from Health Partners telling you that we have received your complaint, and about the first level complaint review process.

You may ask Health Partners to see any relevant information we have about your complaint. You may also send information that may help with your complaint to Health Partners.

If you need more information about help during the complaint/grievance process, see page 39

You may attend the complaint review if you want to. You may come to our offices at 901 Market Street, Suite 500 in Philadelphia or be included by phone or by videoconference. If you decide that you do not want to attend the complaint review, it will not affect our decision.

A committee of one or more Health Partners staff who have not been involved in the issue you filed your complaint about will review your complaint and make a decision. Your complaint will be decided no later than 30 days after we receive your complaint.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you the reason(s) for the decision and what you can do if you don't like the decision.

What to do to continue getting services:

If you have been receiving services or items that are being reduced, changed or stopped and you file a complaint that is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services or items you have been receiving are not covered services or items for you, the services or items will continue until a decision is made.

What if I don't like Health Partners' decision?

Second Level Complaint

If you do not agree with our first level complaint decision, you may file a second level complaint with Health Partners.

When should I file a second level complaint?

You must file your second level complaint within 45 days of the date you receive the first level complaint decision letter. To file a second level complaint, you can:

- Call Health Partners at 1-800-553-0784 or 215-849-9600, TTY 1-877-454-8477 or 215-849-1579 and tell us your second level complaint.

Or

- Write down your second level complaint and send it to us at:
  Complaint & Grievance Dept.
  Health Partners
  901 Market Street, Suite 500
  Philadelphia, PA 19107

What happens after I file a second level complaint?

You will receive a letter from Health Partners telling you that we have received your complaint, and telling you about the second level complaint review process.

You may ask Health Partners to see any relevant information we have about your complaint. You may also send information that may help with your complaint to Health Partners.

You may attend the complaint review if you want to. You may come to our offices at 901 Market Street, Suite 500 in Philadelphia or be included by phone or by videoconference. If you decide that you do not want to attend the complaint review, it will not affect our decision.

A committee made up of three or more people, including at least one person who is not an employee of Health Partners, who has not been involved in the issue you filed your complaint about, will review your complaint and make a decision. Your complaint will be decided no later than 45 days after we receive your complaint.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you the reason(s) for the decision and what you can do if you don't like the decision.

What to do to continue getting services:

If you have been receiving services or items that are being reduced, changed or stopped because they are not covered services or items for you and you file a second level complaint that is hand-delivered or postmarked within 10 days of the date on the first level complaint decision letter, the services or items will continue until a decision is made.

What can I do if I still don't like Health Partners' decision?

External Complaint Review

If you do not agree with Health Partners' second level complaint decision, you may ask for an external review by either the Department of Health or the Insurance Department. The Department of Health handles complaints that involve the way a provider gives care or services. The Insurance Department reviews complaints that involve Health Partners' policies and procedures.

You must ask for an external review within 15 days of the date you received the second level complaint decision letter. If you ask, the Department of Health will help you put your complaint in writing.

You must send your request for external review in writing to either:

Pennsylvania Department of Health
Bureau of Managed Care
Health & Welfare Bldg., Rm. 912
625 Forster Street
Harrisburg, PA 17120-0701
Telephone Number: 1-888-466-2787

Or

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120
Telephone Number: 1-877-881-6388

If you send your request for external review to the wrong department, it will be sent to the correct department.

The Department of Health or the Insurance Department will get your file from Health Partners. You may also send them any other information that may help with the external review of your complaint.

You may be represented by an attorney or another person during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you the reason(s) for the decision and what you can do if you don't like the decision.

What to do to continue getting services:

If you have been receiving services or items that are being reduced, changed or stopped because they are not covered services or items for you and you file an external complaint review that is hand-delivered or postmarked within 10 days of the date on the second level complaint decision letter, the services or items will continue until a decision is made.

Grievances

What is a grievance?

When Health Partners denies, decreases or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a letter (notice) telling you Health Partners' decision.

A grievance is when you tell us you disagree with Health Partners' decision.

What should I do if I have a grievance?

First Level Grievance

To file a grievance, you can:

- Call Health Partners at 1-800-553-0784 or 215-849-9600, TTY 1-877-454-8477 or 215-849-1579 and tell us your grievance.

Or

- Write down your grievance and send it to us at

  Complaint & Grievance Dept.
  Health Partners
  901 Market Street, Suite 500
  Philadelphia, PA 19107

Or

- Your provider can file a grievance for you if you give your provider consent in writing to do so.

NOTE: If your provider files a grievance for you, you cannot file a separate grievance on your own.

When should I file a first level grievance?

You have 45 days from the date you receive the letter (notice) that tells you about the denial, decrease or approval of a different service or item, to file your grievance.

What happens after I file a first level grievance?

After you file your grievance, you will get a letter from Health Partners telling you that we have received your grievance and about the first level grievance review process.

You may ask Health Partners to see any relevant information we have about your grievance. You may also send information that may help with your grievance to Health Partners.

You may attend the grievance review if you want to. You may come to our offices at 901 Market Street, Suite 500 in Philadelphia or be included by phone or by videoconference. If you decide that you do not want to attend the grievance review, it will not affect our decision.

A committee of one or more Health Partners staff, including a licensed doctor, who has not been involved in the issue you filed your grievance about, will review your grievance and make a decision. Your grievance will be decided no later than 30 days after we received your grievance.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you the reason(s) for the decision and what you can do if you don't like the decision.

What to do to continue getting services:

If you have been receiving services or items that are being reduced, changed or stopped, and you file a first level grievance that is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services or items you have been receiving are not covered services or items for you the services or items will continue until a decision is made.

What if I don't like Health Partners' decision?

Second Level Grievance

If you do not agree with our first level grievance decision, you may file a second level grievance with Health Partners.

When should I file a second level grievance?

You must file your second level grievance within 45 days of the date you receive the first level grievance decision letter. To file a second level grievance, you can:

- Call Health Partners at 1-800-553-0784 or 215-849-9600, TTY 1-877-454-8477 or 215-849-1579 and tell us your second level grievance.

Or

- Write down your second level grievance and send it to us at:
  Complaint & Grievance Dept.
  Health Partners
  901 Market Street, Suite 500
  Philadelphia, PA 19107

What happens after I file a second level grievance?

You will receive a letter from Health Partners telling you that we have received your grievance, and telling you about the second level grievance review process.

You may ask Health Partners to see any relevant information we have about your grievance. You may also send information that may help with your grievance to Health Partners.

You may attend the grievance review if you want to. You may come to our offices at 901 Market Street, Suite 500 in Philadelphia or be included by phone or by videoconference. If you decide that you do not want to attend the grievance review, it will not affect our decision.

A committee of three or more people including a doctor and at least one person, who is not an employee of Health Partners, who has not been involved in the issue you filed your grievance about, will review your grievance and make a decision. Your grievance will be decided no later than 45 days after we receive your grievance.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you the reason(s) for the decision and what you can do if you don't like the decision.

If you need more information about help during the complaint/grievance process, see page 39

What to do to continue getting services:

If you have been receiving services or items that are being reduced, changed or stopped and you file a second level grievance that is hand-delivered or postmarked within 10 days of the date on the first level grievance decision letter, the services or items will continue until a decision is made.

What can I do if I still don't like Health Partners' decision?

External Grievance Review

If you do not agree with Health Partners' second level grievance decision, you may ask for an external grievance review.

You must call or send a letter to Health Partners asking for an external grievance review within 15 days of the date you received our grievance decision letter. To ask for an external grievance review, you can:

- Call Health Partners at 1-800-553-0784 or 215-849-9600, TTY 1-877-454-8477 or 215-849-1579 and tell us your second level grievance.

Or

- Write down your second level grievance and send it to us at:

Complaint & Grievance Dept.
Health Partners
901 Market Street, Suite 500
Philadelphia, PA 19107

We will then send your request to the Department of Health.

The Department of Health will notify you of the external grievance reviewer's name, address and phone number. You will also be given information about the external review process.

Health Partners will send your grievance file to the reviewer. You may provide any additional information that may help with the external review of your grievance to the reviewer within 15 days of filing the request for an external grievance review.

You will receive a letter within 60 days of the date you asked for an external grievance review. This letter will tell you the reason(s) for the decision and what you can do if you don't like the decision.

If you need more information about help during the complaint/grievance process, see page 37

What to do to continue getting services:

If you have been receiving services or items that are being reduced, changed or stopped and you request an external grievance review that is hand-delivered or postmarked within 10 days of the date on the second level grievance decision letter, the services or items will continue until a decision is made.

You may call Health Partners' toll-free telephone number at 1-800-553-0784 if you need help or have questions about complaints and grievances. You can contact your local legal aid office (see page 45 for the office closest to you) or call the Pennsylvania Health Law Project at 1-800-274-3258.

What can I do if my health is at immediate risk?

Expedited Complaints and Grievances

If your doctor or dentist believes that the usual timeframes for deciding your complaint or grievance will harm your health, you or your doctor or dentist can call Health Partners at 1-800-553-0784 or 215-849-9600, TTY 1-877-454-8477 or 215-849-1579 and ask that your complaint or grievance be decided faster. You will need to have a letter from your doctor or dentist faxed to 215-991-4105

explaining how the usual timeframe for deciding your complaint or grievance will harm your health.

If your doctor or dentist does not fax Health Partners this letter, your complaint or grievance will be decided within the usual timeframes.

Expedited Complaint

The expedited complaint will be decided by a licensed doctor who has not been involved in the issue you filed your complaint about.

Health Partners will call you with our decision within 48 hours of when we receive the letter from your doctor or dentist explaining how the usual timeframe for deciding your complaint will harm your health or within 3 business days of your request for an expedited (faster) complaint review, whichever is sooner. You will also receive a letter telling you the reason(s) for the decision and how to file an external complaint, if you don't like the decision. For information on how to file an external complaint, see page 38.

Expedited Grievance and Expedited External Grievance

A committee of three or more people, including a licensed doctor and at least one Health Partners member, will review your grievance. The licensed doctor will decide your expedited grievance with help from the other people on the committee. No one on the committee will have been involved in the issue you filed your grievance about.

Health Partners will call you with our decision within 48 hours of when we receive the letter from your doctor or dentist explaining how the usual timeframe for deciding your grievance will harm your health decision or within 3 business days of your request for an expedited (faster) grievance review, whichever is sooner. You will also receive a letter telling you the reason(s) for the decision and how to file an expedited external grievance, if you don't like the decision.

If you want to ask for an expedited external grievance review by the Department of Health, you must call Health Partners at 1-800-553-0784 or 215-849-9600, TTY 1-877-454-8477 or 215-849-1579 within two business days from the date you get the expedited grievance decision letter. Health Partners will send your request to the Department of Health within 24 hours after receiving it.

What kind of help can I have with the complaint and grievance processes?

If you need help filing your complaint or grievance, a staff member of Health Partners will help you. This person can also represent you during the complaint or grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your complaint or grievance.

You may also have a family member, friend, lawyer or other person help you file your complaint or grievance. This person can also help you if you decide you want to appear at the complaint or grievance review. For legal assistance you can contact your local legal aid office.

(See page 45 for the legal aid office closest to you.)

At any time during the complaint or grievance process, you can have someone you know represent you or act on your behalf. If you decide to have someone represent you or act for you, tell Health Partners, in writing, the name of that person and how we can reach him or her.

You or the person you choose to represent you may ask Health Partners to see any relevant information we have about your complaint or grievance.

Persons Whose Primary Language is not English

If you ask for language interpreter services, Health Partners will provide the services at no cost to you. Please contact the Member Relations department at 1-800-553-0784 or 215-849-9600, TTY 1-877-454-8477 or 215-849-1579 for more information.

Persons with Disabilities

Health Partners will provide persons with disabilities in presenting complaints or grievances at no cost. This help includes:

- Providing sign language interpreters;
- Giving you information that Health Partners plans to submit at the complaint or grievance review in an alternative format, before the review; and
- Providing someone to help copy and present information.

NOTE: For some issues you can request a fair hearing from the Department of Public Welfare in addition to or instead of filing a complaint or grievance with Health Partners.

See next page for the reasons you can request a fair hearing.

Department of Public Welfare Fair Hearings

In some cases you can ask the Department of Public Welfare to hold a hearing because you are unhappy about or do not agree with something Health Partners did or did not do. These hearings are called "fair hearings." You can ask for a fair hearing at the same time you file a complaint or grievance or you can ask for a fair hearing after Health Partners decides your first or second level complaint or grievance.

How do I ask for a fair hearing?

You must ask for a fair hearing in writing and send it to:

Department of Public Welfare
Office of Medical Assistance Programs —
HealthChoices Program
Complaints, Grievances and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

Your request for a fair hearing should include the following information:

- Member name;
- Member social security number and date of birth;
- A telephone number where you can be reached during the day;
- If you want to have the fair hearing in person or by telephone; and
- Any letter you have received about the issue you are requesting your fair hearing for.

What happens after I ask for a fair hearing?

You will get a letter from the Department of Public Welfare's Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the fair hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the fair hearing.

Health Partners will also go to your fair hearing to explain why we made the decision or explain what happened.

If you ask, Health Partners must give you (at no cost to you) any records, reports and other information we have that is relevant to what you requested your fair hearing about.

When will the fair hearing be decided?

If you ask for a fair hearing after a first level complaint or grievance decision, the fair hearing will be decided no more than 60 days after the Department of Public Welfare gets your request.

If you ask for a fair hearing and did not file a first level complaint or grievance, or if you ask for a fair hearing after a second level complaint or grievance decision, the fair hearing will be decided within 90 days from when the Department of Public Welfare gets your request.

If your fair hearing is not decided within 90 days from the date the Department of Public Welfare receives your request, you may be able to get your services until your fair hearing is decided. You can call the Department of Public Welfare at 1-800-798-2339 to ask for your services.

Interim Assistance

If your appeal is not decided within the 90 days from the date the Department of Public Welfare receives your request, you may be able to receive interim medical assistance until the decision is made. To learn more about interim assistance, contact the Member Relations department at 1-800-553-0784 or 215-849-9600, TTY 1-877-454-8477 or 215-849-1579 or call your County Assistance Office.

What kind of things can I request a fair hearing about and by when do I have to ask for my fair hearing?

If you are unhappy because…	You must ask for a fair hearing…
1) Health Partners decided to deny a service or item because it is not a covered service or item;	within 30 days of getting a letter from Health Partners telling you of this decision.
2) Health Partners decided not to pay a provider for a service or item you got and the provider can bill you for the service or item;	within 30 days of getting a letter from Health Partners telling you of this decision.
3) Health Partners did not decide within 30 days, a complaint or grievance you told Health Partners about before;	within 30 days of getting a letter from Health Partners telling you that we did not decide your complaint or grievance within the time we were supposed to.
4) Health Partners decided to deny, decrease or approve a service or item different than the service or item you requested because it was not medically necessary;	within 30 days of getting a letter from Health Partners telling you of this decision or within 30 days of getting a letter from Health Partners telling you its decision after you filed a complaint or grievance about this issue.
5) Health Partners did not provide a service or item by the time you should have received it. (The time by which you should have received a service or item is listed on page 8 of this **handbook).**	within 30 days from the date you should have received the service or item.

What to do to continue getting services:

If you have been receiving services or items that are being reduced, changed or stopped and your request for a fair hearing is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that Health Partners has reduced, changed or denied your services or items or telling you Health Partners' decision about your first or second level complaint or grievance, your services or items will continue until a decision is made.

If you have been notified that you are being placed in DPW's Recipient Restriction Program and your request for a fair hearing is hand-delivered or postmarked within 10 days of the date on the notice, the restriction will not be put in place until the fair hearing decision is made.

What can I do if my health is at immediate risk?

Expedited Fair Hearing

If your doctor or dentist believes that using the usual timeframes to decide your fair hearing will harm your health, you or your doctor or dentist can call the Department of Public Welfare at 1-800-798-2339 and ask that your fair hearing be decided faster. This is called an expedited fair hearing.

You will need to have a letter from your doctor or dentist faxed to 717-772-6328 explaining why using the usual timeframes to decide your fair hearing will harm your health. If your doctor or dentist does not send a written statement, your doctor or dentist may testify at the fair hearing to explain why using the usual timeframes to decide your fair hearing will harm your health.

The Bureau of Hearings and Appeals will contact you to schedule the expedited fair hearing. The expedited fair

hearing will be held by telephone within 3 business days after you ask for the fair hearing.

If your doctor does not send a written statement and does not testify at the fair hearing, the fair hearing decision will not be expedited. Another hearing will be scheduled, and the time frame for the fair hearing decision will be based on the date you asked for the fair hearing.

If your doctor sent a written statement or testifies at the hearing, the decision will be made within 3 business days after you asked for the fair hearing.

You may call Health Partners' toll-free telephone number at 1-800-553-0784, TTY 1-877-454-8477 if you need help or have questions about fair hearings, you can contact your local legal aid office (see page 45 for the office closest to you) or call the Pennsylvania Health Law Project at 1-800-274-3258.

Loss of Benefits

The process which results in ending your Health Partners coverage is called disenrollment. Reasons for being disenrolled include but are not limited to:

- Moving out of the HealthChoices service area
- Losing Medical Assistance eligibility
- Spending more than 30 days in a nursing home
- Placement in a youth development center
- Placement in a juvenile detention center for more than 35 days
- Imprisonment

You can also choose to disenroll for any reason. If you choose to leave Health Partners, you must talk to an enrollment specialist at your County Assistance Office or by calling 1-800-440-3989. If you are calling from a TTY phone, please call 1-800-618-4225. However, we value you as a Health Partners member, and hope that you will call the Member Relations department if you are thinking about leaving. This way, you can give us the chance to help fix any problems you may be having. You are important to us!

What to Do If You Receive a Bill

There may be times when you are billed for services you receive, based on your level of benefit. Your provider cannot bill you unless he or she tells you that you will have to pay for the service before you get the service. If you think that your benefit level is not correct, contact your County Assistance Office for help.

If a participating Medicaid provider should ever bill you for the balance of a covered medical service, you do not have to pay. Health Partners members are never responsible to pay participating Medicaid providers any amount for covered medical services, other than approved coinsurance or copayment amounts as part of your benefit package.

Even if a participating Medicaid provider has not received payment from Health Partners for covered services, you are not responsible for payment.

Sometimes, by mistake, you may receive a bill in the mail from your hospital or doctor. If you do receive a bill:

1. Open it right away.
2. Do not pay it. Just write "Health Partners" and your Health Partners identification number from your ID card on the bill.
3. Mail the bill back to the office that sent it to you. The address of the office is usually in the upper left-hand corner or lower right-hand corner of the bill.

If you follow these steps right away, you should not receive any more bills for your health care as long as you are going to Health Partners participating doctors, specialists, hospitals and pharmacies. If you do get another bill for your health care, or if you have questions about what to do when you get a bill, call Health Partners' Member Relations department at 1-800-553-0784 or 215-849-9600, TTY 1-877-454-8477 or 215-849-1579.

Healthcare Services Phone Surveys

From time to time, Health Partners calls members to check whether they have received healthcare services for which Health Partner has been billed.

Our phone survey asks if you received a healthcare service on a certain date. To protect your privacy, our phone message does not identify the service. You may get a call after you have a doctor or dentist or emergency room visit, after you fill a prescription, or after getting any other healthcare service.

When we call, just choose "Yes" or "No" to tell us whether you received a service on this date. When you take part in these phone surveys you help us meet an important quality standard.

Please call Member Relations anytime at 1-800-553-0784 (TTY 1-877-454-8477) if you have any questions about these phone surveys.

Fraud and Abuse: Special Investigations Unit

Health Partners' Special Investigations Unit (SIU) looks into the behavior of Health Partners doctors and other providers, Health Partners members, and Health Partners employees. The SIU checks to see if these people act in a way that is not legal or is not ethical (wrong).

Members who believe that providers, other members or Health Partners employees have acted in a way that is not legal or is not ethical (wrong) should call the Health Partners' SIU Hotline at 1-866-477-4848.

This hotline is for reporting the behavior of members, providers and employees. You do not need to tell us your name or phone number when you call our hotline, just share with us what you would like about the actions that you think may be wrong.

These are some examples of behavior that is not legal or is not ethical:

- Providers who submit claims for services they did not provide
- Providers who submit a bill for a more expensive service than the one he or she actually did
- A provider who pays a member to see him or her
- Providers who submit more than one bill for the same service
- Providers who perform services that are not necessary or that a patient does not need done
- Providers who abuse a patient physically, mentally, emotionally or sexually
- Providers who offer a member free services, equipment or supplies in exchange for the member's Medical Assistance ID number and then use that ID number to bill Health Partners for services never provided
- A pharmacist who pays providers for referrals
- A pharmacist who gives generic drugs but bills for brand name drugs
- Members allowing others to use their membership cards or ID numbers
- Members who sell medicines they receive through Health Partners

Tips for Recognizing Fraud and Abuse Issues

When Receiving Services at a Provider's Office

When a medical procedure is recommended, make sure the doctor explains to you why you need the procedure.

When Filling Prescriptions

Ask the pharmacist how many pills are in the bottle to make sure that it is the same amount the doctor prescribed for you.

When asking someone to take your prescription to be filled at the pharmacy on your behalf, make sure that you know and trust that person.

When Attending a Gym or Physical Therapy Facility

Make sure you initial or sign gym cards ONLY for completed visits. Do not allow someone to have you initial or sign for any visits that you are planning to complete, but have not yet completed.

Safeguards to Protect Your Health Partners Member Identification Card

Keep your Health Partners member identification card in a safe place. Check often to make sure that the card is not missing.

Show your Health Partners member identification card or provide your Health Partners identification number only to your healthcare providers or administrators and pharmacists.

Do not leave any documents showing your Health Partners member identification number in public places.

When receiving your healthcare services, Health Partners recommends that you:

Be Cautious.
Be Alert.
Be Safe.

If you see or hear about any wrongdoing, please make a note of what YOU think is wrong and call the Health Partners SIU Hotline at 1-866-477-4848, TTY 1-877-454-8477 or 215-849-1579. You can use our Health Partners Hotline number to report any suspected wrongdoing about doctors, providers, members and/or employees of Health Partners. An easy way to remember our number is1-866-HP-SIU-4U. You can also report providers to the State's hotline at the phone number listed below for DPW.

MA Provider Compliance Hotline: 1-866-DPW-TIPS

The MA Provider Compliance Hotline, established by and located in the DPW Bureau of Program Integrity, is designed to provide easy access for reporting suspected fraudulent and abusive practices by providers in fee-for-service and managed care within the Pennsylvania MA Program. The Hotline is staffed with medical professionals who are available from 8:30 a.m. to 3:30 p.m. (Eastern Time), Monday through Friday. Voice messaging is available outside these hours. Non-English speaking interpreter services are available to provide assistance to callers and TTY services for persons with hearing impairment are also available.

- Callers to the Hotline are not required to identify themselves.
- If a caller does not wish to speak to a Hotline representative directly, please leave a message outside the hours of operation.
- You may report suspected fraudulent and abusive practices without disclosing your identity by completing and submitting the response form found on the DPW website.

Please have the following information when you call:

- Provider's name and address
- Description of the suspected fraudulent and abusive activity, including the time period, frequency of the events, recipient name, and recipient ID number

- Telephone number where you can be reached, in the event that you want to be contacted

Contact Information for Fraud and Abuse Reporting:

If you have knowledge of suspected MA provider noncompliance, or of substandard quality of care for services paid for under the Pennsylvania Medical Assistance Program, please contact the MA Provider Compliance Hotline by:

- Telephone (includes TTY service): 1-866-DPW-TIPS (1-866-379-8477)
- Fax: (717) 772-4655 - Attention: MA Provider Compliance Hotline
- Electronically submitting the MA Provider Compliance Hotline Response Form (http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/maprovidercompliancehotlineresponseform/index.htm)
- U.S. Mail:
  Bureau of Program Integrity
  MA Provider Compliance Hotline
  P.O. Box 2675
  Harrisburg, PA 17105-2675

Recipient Restriction Program

Health Partners participates in the DPW Recipient Restriction Program. The program calls for Health Partners to keep an eye out for and identify those who may abuse the Medical Assistance program. In partnership with DPW's Bureau of Program Integrity, for Medicaid Recipients, Health Partners will refer members with suspected patterns of abuse to the Recipient Restriction Program. After DPW investigates, those members may be limited to a certain provider or pharmacy, or both, for a period of five years.

Restricted members can request a provider change. The request must be written. The restriction coordinator will complete the provider change request within 30 days, and notify the member. Provider change requests should be sent to:

Attn: Recipient Restriction Coordinator
Pharmacy Department
Health Partners
901 Market Street, Suite 500
Philadelphia, PA 19107

Requests may also be sent to Health Partners for forwarding to the Department of Public Welfare:

Attn: Member Relations
Health Partners
901 Market Street, Suite 500
Philadelphia, PA 19107

Members cannot file a complaint or grievance, but may ask for a DPW Fair Hearing about the recipient restriction program. A written request must be sent to:

Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Program Integrity
Recipient Restriction Section
P.O. Box 2675
Harrisburg, PA 17105-2675

For More Information

If you have any questions or need more information about your benefits or any Health Partners services, call our Member Relations department at 1-800-553-0784 or 215-849-9600. If you are calling from a TTY phone, call 1-877-454-8477 or 215-849-1579. You can ask for more written information about Health Partners and its policies.

This information includes:

- A list of names, addresses and titles of members of Health Partners' Board of Directors
- A description of the plan's confidentiality policy
- A description of the provider credentialing process for reviewing providers who want to participate in the Health Partners network
- A list of participating providers affiliated with participating hospitals
- A list of participating PCPs, specialists, pharmacies and providers of ancillary services in an appropriate alternate format
- A copy of the plan's medical guidelines (utilization criteria) used in reviewing your request for care
- Whether a specific drug is covered
- A summary of how Health Partners pays providers for their services
- A description of the plan's Quality Management program
- Information about the cost of health care covered by Health Partners