

**Overview**

The Plan will ensure that members are aware of the role of the PCPs, how to obtain care, what to do in an emergency or urgent medical situation and their rights and responsibilities. The Plan will convey this information through various methods including a Member Handbook.

**Member Handbook**

All newly enrolled members will receive a Member Handbook within 10 business days of receiving the notice of enrollment from the Plan.

**Member Rights**

Harmony members have the following rights:

- To be treated with respect and courtesy by their health care providers and their office staff, and all Harmony staff;
- To select their own PCP;
- To refuse treatment;
- To be treated with due consideration for his or her dignity, privacy and confidentiality;
- To receive care consistent with sound nursing and medical practices;
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand, before treatment begins;
- To participate in decisions regarding his/her health care, including the right to refuse treatment to the extent of the law and to be told of the outcome;
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;

- To request and receive a copy of his/her medical records (one copy per year at no cost to the Member), and to request that they be amended or corrected;
- To voice concerns or complaints about the program and receive prompt answers;
- To be free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member.
- To request information relating to Harmony's Physician Incentive Plan;
- To request a description of the financial relationships between Harmony and any health care provider by contacting Member Services.

Harmony members have the right to request the following information from Harmony's participating health care providers:

- Copy of the total bill for services received from member's health care provider;
- Educational background, experience, training, specialty and board certification;
- The names of the licensed facilities in Harmony's network where the health care provider presently has privileges for the treatment, illness, or procedure for which the member is inquiring;
- Information about the health care provider's participation in continuing education programs;
- Compliance with licensure, certification or registration requirements.

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**Member  
Identification  
Cards**

Member identification cards are intended to identify Plan members and facilitate their interactions with physicians and other health care providers. Information found on the member identification card may include the member's name, identification number, primary care physician's name and telephone number, co-payment information, 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.

**Eligibility  
Verification**

A member's eligibility status can change at anytime. Therefore, all providers should consider requesting and copying a member's identification card, along with additional proof of identification, such as a photo ID, and file them in the patient's medical record.

PCPs may also refer to their current monthly membership listing to verify eligibility. If the member does not appear on the list, you may do one of the following to verify eligibility:

- Access the Plan's Interactive Voice Response (IVR) system. You will need your Provider ID number to access member eligibility.
- Contact the Customer Service department.

To ensure newly enrolled Plan members have immediate access to services, the provider shall accept the member's Medicaid ID Card as proof of enrollment until the member receives the Plan's ID card by following the eligibility verification steps outlined above.

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

See your provider agreement for additional details.

**Enrollment**

Membership enrollments in the Plan's Medicaid program may be voluntary or by state-mandated assignment.

The Plan accepts members without consideration of the applicant's health condition, sex, race, religious belief, national origin or handicap. Upon enrollment in the Plan, members are provided with the following:

- Terms and conditions of enrollment;
- Description of covered services;
- Information about PCPs; such as location, telephone number and office hours;
- Information regarding out-of-plan emergency services;
- Grievance and disenrollment procedures;
- Over-the-counter brochure, if applicable.

**Assignment of  
Primary Care  
Physician**

All Medicaid Plan members must choose their PCP or they will be assigned to a PCP within the Plan's network. To ensure quality and continuity of care, the PCP is responsible for arranging all of the member's health care needs from providing primary care services to coordinating referral to specialists and providers of ancillary or hospital services.

**Changing Primary  
Care Physicians**

A member may change his or her PCP at any time by calling the Customer Service department. The requested change will be effective the first day of the month following the request.

**Hearing Impaired,  
Interpreter and  
Sign Language  
Services**

Hearing impaired, interpreter and sign language services are available to Plan members through the Customer Service department. PCPs should coordinate these services for Plan members and contact the Plan's Customer Service department if assistance is needed.

Please refer to the **Quick Reference Guide** for the Customer Service telephone numbers.

