

PROVIDER MANUAL SUPPLEMENT
MANAGED CARE

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MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

Managed Care is a health care delivery model implemented by the South Carolina Department of Health and Human Services (SCDHHS) to establish a medical home for all Medicaid Managed Care eligible members. The goals of a medical home include:

- Provide accessible, comprehensive, family-centered coordinated care
- Manage the member's health care, perform primary and preventive care services, and arrange for any additional needed care
- Provide members access to a "live voice" 24 hours a day, 7 days a week, to ensure access to appropriate care
- Provide member education about preventive and primary health care, utilization of the medical home, and the appropriate use of the emergency room

Enrolling in a managed care plan does not limit benefits. Benefits offered under fee for service (FFS) Medicaid, as well as additional or enhanced benefits are provided by all Managed Care Organizations (MCOs). These additional benefits vary from MCO to MCO according to the contracted terms and conditions between SCDHHS and the managed care entity. Members and providers should contact the MCO with questions concerning additional benefits.

Examples of additional benefits include:

- 24-hour nurse advice line
- Care coordination
- Health management programs (asthma, diabetes, pregnancy, etc.)
- Unlimited office visits
- Waving Co-pays on some services

The Managed Care Division administers the program for Medicaid-eligible members by contracting with Managed Care Organizations (MCOs) to offer health care services. An MCO must receive a Certificate of Authority from the SC Department of Insurance and be licensed as a domestic insurer by the State to render Medicaid managed care services. MCO model contracts are approved by the Centers for Medicare and Medicaid Services (CMS) and the South Carolina Department of Health and Human Services (SCDHHS).

This Managed Care supplement is intended to provide an overview of the Managed Care program. Providers should review the Managed Care Policy and Procedure Guide and the Managed Care contract for detailed program-specific requirements. Both the guide and the contract are located on the SCDHHS Web site at www.scdhhs.gov within the Managed Care section.

The Exhibits section of this supplement provides contact information for MCOs currently participating in the Medicaid Managed Care program as MCOs are subject to change at any time. Providers are encouraged to visit the SCDHHS website (www.scdhhs.gov) for the most current listing of MCOs, the counties in which they are authorized to operate, and the number of managed care enrollees within a county.

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SC MEDICAID MANAGED CARE CONTACT INFORMATION

For additional information, contact the Managed Care Division at the following address:

South Carolina Department of Health and Human Services
Managed Care Division
Post Office Box 8206
Columbia, SC 29202-8206

PROGRAM DESCRIPTION

Managed Care Organizations (MCOs)

A Managed Care Organization (MCO) is commonly referred to as an HMO (Health Maintenance Organization) in the private sector. MCOs are required to operate under a contract with SCDHHS to provide healthcare services to beneficiaries through a network of healthcare professionals, both primary and specialty care, as well as hospitals, pharmacies, etc. This network is developed by contracting with the various healthcare professionals. Providers wanting to contract with an MCO must be enrolled in South Carolina Medicaid with SCDHHS.

Primary care providers (PCP) must be accessible within a thirty (30) mile radius, while specialty care providers, to include hospitals, must be accessible within a fifty (50) mile radius. While MCOs will contract with providers within a specific county, enrolled members may seek treatment, or be referred to in-network providers in other counties.

MCOs are responsible for providing core services to Medicaid-eligible individuals as specified in their contract with SCDHHS. The health care providers within the MCO network are not required to accept FFS Medicaid but must be enrolled as a provider with SCDHHS.

Core Benefits

Managed Care Organizations are fully capitated plans that provide a core benefit package similar to the current FFS Medicaid plan. MCO plans are required to provide members with “medically necessary” care for all contracted services. While appropriate and necessary care must be provided, MCOs are not bound by the current variety of service settings. For example, a service may only be covered FFS when performed in an inpatient hospital setting, while the MCO may authorize the same service to be performed both in an inpatient and an outpatient hospital setting.

MCOs may offer SCDHHS-approved additional benefits. These are benefits that go beyond the core package. Additions, deletions, or modifications to additional benefits made by the MCO must be approved by SCDHHS. These benefits may include medical services which are currently non-covered by FFS and/or which exceed current Medicaid limitations.

Providers should refer to the **Core Benefits** section of the MCO Policy and Procedures Guide on the SCDHHS website (www.scdhhs.gov) for a detailed explanation of core benefits.

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Services Outside of the Core Benefits

The South Carolina Healthy Connections (Medicaid) program continues to provide and/or reimburse certain FFS benefits. Providers rendering services that are not included in the MCO's benefits package, but are covered under FFS Medicaid receive payment in accordance with the current Medicaid fee schedule. These services are filed to SC Medicaid for processing and payment. MCOs are responsible for the member's continuity of care by ensuring appropriate referrals and linkages to the Medicaid FFS providers. For specifics concerning services outside of the core benefits, please see the Managed Care Policy and Procedures Guide on the SCDHHS website www.scdhhs.gov.

MCO Program Identification (ID) Card

Managed Care Organizations issue an identification card to beneficiaries within fourteen (14) calendar days of the selection of a primary care provider, or the date of receipt of the member's enrollment data from SCDHHS, whichever is later.

To ensure immediate access to services, the provider should verify eligibility and enrollment through the Medicaid provider web tool regardless of a member's ability to supply a SC Medicaid or MCO ID card. The MCO ID card must include at least the following information:

- The MCO name
- The 24-hour telephone number for the member to use in urgent or emergency situations and to obtain any additional information
- The name of the primary care physician
- The member's name and Medicaid ID number
- The MCO's plan expiration date (optional)
- The Member Services toll-free telephone number
- The MCO and SC Medicaid logos

Claims Filing

Providers should file claims with the MCO for members participating in a managed care program, unless the service rendered is not covered by the MCO and is, instead, paid on a FFS basis by SC Medicaid. Providers should contact the MCO for managed care billing requirements. Non-contracted providers should contact the MCO for billing and prior authorization requirements prior to rendering services to MCO enrolled members. An exception is services rendered in an emergency room. Even if the physician is not in-network with the MCO, the MCO cannot refuse to reimburse for covered emergency services. Specifics concerning emergency coverage can be found in the MCO contract and Managed Care Policy and Procedure Guide.

Prior Authorizations and Referrals

Providers, both in and out of network, should contact the member's MCO for assistance with prior authorization (PA) requirements before administering services. Each MCO may have different

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prior authorization requirements and services requiring PA.PA requirements may also differ according to the terms of a provider's contract with an MCO.

Admission to a hospital through the emergency department **may** require authorization. Hospitals should always check with the beneficiary's MCO for their requirements. Specialist referrals for follow-up care after a hospital discharge may also require prior authorization.

Medical Homes Networks (MHNs) - Medically Complex Children's Waiver

SCDHHS administers one MHN specifically for individuals that are enrolled in the Medically Complex Children's Waiver program. Medical Homes Networks (MHNs) are Primary Care Case Management (PCCM) programs that link beneficiaries with a primary care provider (PCP). An MHN is a group of physicians who have agreed to serve as PCCM providers for this specific population. They work in partnership with the member to provide and arrange for most of the beneficiary's health care needs, including authorizing services provided by other health care providers. They also partner with a Care Coordination Services Organization (CSO) to accept the responsibility for providing medical homes for members and managing their care. The CSO supports the physicians and enrolled beneficiaries by providing care coordination, disease management, and data management.

The outcome of this medical home is a healthier, better educated Medicaid member, and cost savings for South Carolina through a reduction of acute medical care and disease-related conditions. The MHN provides case managers, who assist in developing, implementing, and evaluating the predetermined care management strategies of the network.

MHN Program Identification (ID) Card - Medically Complex Children's Waiver

A separate identification card is not issued for members enrolled in this program. Beneficiaries enrolled in this MHN will have only one identification card, the one issued by SC Medicaid. This card does not contain the name or phone number of the assigned PCP. Such information can only be obtained by checking eligibility at the Medicaid provider web tool.

Core Benefits - Medically Complex Children's Waiver

Services provided under this MHN program are all paid on a FFS basis. As such, all claims are submitted to and processed by SCDHHS. Benefits offered in the MHN program mirror those offered in FFS Medicaid.

Prior Authorizations and Referrals - Medically Complex Children's Waiver

The PCP is contractually required to either provide medically necessary services or authorize another provider to treat the member via a referral. If a member has failed to establish a medical record with the PCP, the CSO, in conjunction with the PCP, shall arrange for the prior authorization (PA) on any existing referral. For a list of services that do not require authorization, refer to the **Exempt Services** section later in this supplement.

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In some cases, the PCP may choose to authorize a service retroactively. All authorizations and consultations, including services authorized retroactively, are at the discretion of the PCP. The process for referring a member to a specialist can be made by telephone or in writing. The referral should include the number of visits being authorized and the extent of the diagnostic evaluation.

A PCP may authorize multiple visits for a specific course of treatment or a particular diagnosis. This prevents a provider to whom the member was referred from having to obtain a referral number for each visit so long as the course of treatment or diagnosis has not changed. The provider simply files the claims referencing the same referral number. It is the PCP's responsibility to authorize additional referrals for any further diagnosis, evaluation, or treatment not identified in the scope of the original referral. If a specialist needs to refer the member to a second specialist for the same diagnosis, the beneficiary's PCP must be contacted for a referral number.

A referral number is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the physician component for inpatient hospital services does require a referral number. The hospital should contact the PCP for a referral number within 48 hours of the member's admission. Specialist referrals for follow-up care after discharge from a hospital also require a referral from the PCP. In addition to the MHN's authorization, prior approval may be required by SCDHHS to verify medical necessity before rendering some services. Prior authorizations are for medical approval only. Obtaining a prior authorization does not guarantee payment or ensure the member's eligibility on the date of service. Claims submitted for reimbursement must include the PCP's referral number.

Specific services sponsored by state agencies require a referral from that agency's case manager. The state agency's case manager should coordinate with the PCP and the MHN Care Coordinator to ensure the continuity of care. These services include, but are not limited to, the following:

- Audiologist Services
- High/Moderate Management Group Homes Services
- Occupational Therapist Services
- Physical Therapist Services
- Psychologist Services
- Speech Therapist Services
- Therapeutic Foster Care Services

Referrals for a Second Opinion - Medically Complex Children's Waiver

PCPs are required to refer a member for a second opinion at his or her request when surgery is recommended.

Referral Documentation - Medically Complex Children's Waiver

All referrals must be documented in the member's medical record. The CSO and the PCP shall review the monthly referral data to ensure that services rendered to the beneficiary were authorized

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and recorded accurately in the medical record. It is the PCP's responsibility to review the referral data for validity and accuracy, and to report inappropriate and/or unauthorized referrals to the CSO. The CSO is responsible for investigating these incidents and notifying SCDHHS if Medicaid fraud or abuse is suspected.

Exempt Services - Medically Complex Children's Waiver

Beneficiaries can obtain the following services from Medicaid providers without obtaining a prior authorization from their PCP:

- Ambulance Services
- Dental Services
- Dialysis/End Stage Renal Disease Services
- Emergency Room Services (billed by the hospital)
- Family Planning Services
- Home- and Community-Based Waiver Services
- Independent Laboratory and X-ray Services¹
- Medical Transportation Services
- Nursing Home Services
- Obstetrician and Gynecologist Services
- Optician Services
- Optometrist Services
- Pharmacy Services
- State Agency Services²

Some services still require a prescription or a physician's order. Physicians should refer to the appropriate Medicaid Provider Manual for more detailed information and/or requirements, or contact the SCDHHS Provider Service Center (PSC) by calling (888) 289-0709. Providers can also submit an online inquiry at <https://scdhhs.gov/webform/contact-provider-representative> and a provider support representative will respond to the request.

¹ FQHCs/RHCs that provide laboratory and x-ray services under a separate provider number (not the FQHC/RHC number) must enter a prior authorization number on the claim form or the claim will be rejected.

² Agencies exempt from prior authorization are the Department of Mental Health, the Continuum of Care, the Department of Alcohol and Other Drug Abuse, the Department of Disabilities and Special Needs, the Department of Juvenile Justice, and the Department of Social Services.

MANAGED CARE SUPPLEMENT**MANAGED CARE OVERVIEW*****Primary Care Provider Requirements - Medically Complex Children's Waiver***

The primary care provider is required to either provide services or authorize another provider to treat the member. The following Medicaid provider types may enroll as a primary care provider:

- Family Medicine
- General Practitioners
- Pediatricians
- Internal Medicine
- Obstetrics and Gynecology
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Nurse Practitioners

24-Hour Coverage Requirements - Medically Complex Children's Waiver

The MHN requires PCPs to provide access to medical advice and care for enrolled members 24 hours per day, 7 days per week. A qualified medical practitioner must provide medical advice, consultation, and/or authorization or referral for services when appropriate within one hour of the member's presentation or notification. PCPs must have at least one telephone line that is answered by office staff during regular office hours.

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MANAGED CARE SUPPLEMENT

MANAGED CARE ELIGIBILITY

Individuals must apply for SC Medicaid prior to enrollment in a Managed Care Organization.. If the applicant meets the established Medicaid eligibility requirements, he or she may be eligible for participation in the South Carolina Medicaid Managed Care program. Not all Medicaid members participate in the Managed Care program.

The following Medicaid members do not participate in the South Carolina Medicaid **Managed Care program**:

- Dually eligible Members (Medicare and Medicaid)*
- Members age 65 or older*
- Residents of a nursing home*
- Participants in limited benefits programs such as Family Planning, Specified Low Income Beneficiaries, Emergency Service Only, etc.
- Home- and Community-Based Waiver participants*
- PACE participants
- Medically Complex Children's Waiver Program participants
- Hospice participants
- Members covered by an MCO/HMO through third-party coverage
- Members enrolled in another Medicaid managed care plan (Medical Home Network)

Providers should verify the member's eligibility through the Web Tool or a point-of-service (POS) terminal prior to delivering services.

*SCDHHS along with the Centers for Medicare and Medicaid Services (CMS) currently operate a dual demonstration grant, SC Healthy Connections PRIME, where Medicaid managed care enrollment of these membership groups are allowed. For more information regarding the SC Healthy Connections PRIME program please access the SCDHHS website <https://scdhhs.gov/service/healthy-connections-prime>.

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MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

OVERVIEW

All managed care enrollment and disenrollment activities are handled through one single point of contact, South Carolina Healthy Connections Choices (SCHCC). SCHCC is responsible for processing the enrollment and disenrollment of Medicaid-eligible members into a managed care plan. Members may enroll online, by telephone, by mail, or by fax. Managed Care eligible Medicaid members are encouraged to actively enroll with a managed care plan.

SCHCC may be reached by calling (877) 552-4642, or via the SCHCC website: www.SCchoices.com. SCHCC should be contacted for assistance with enrollment, as well as transferring to, or disenrolling from, an MCO regardless of how long a member has been enrolled in their current MCO.

Members who are eligible for managed care participation are made aware of their eligibility via an outreach or enrollment mailing from SCHCC.

An **enrollment packet** is mailed to members who are required to make a managed care plan choice. Failure to do so will result in managed care plan assignment by SCHCC.

An **outreach packet** is mailed to beneficiaries who are eligible, but not required, to participate in a managed care plan. Managed care participation is on a voluntary basis for this population.

Outreach and assignment is based on the member's eligibility category and/or Special Program enrollment, member assignment to an MCO is done on a prospective basis.

If a Medicaid member enrolled in a MCO loses Medicaid eligibility, but regains it within sixty (60) days, he or she will be automatically reassigned to the same plan and will forego a new ninety (90) day choice period.

Members cannot enroll directly with the MCO. Members must contact SCHCC to enroll in a managed care plan, or to change or discontinue their enrollment. A member can only change or disenroll without cause within the first ninety (90) days of enrollment. If the member is approved to enroll in a managed care plan, or changes his or her plan, prior to SCDHHS' creation of the MCO member list which is done in the next to last week of each month, the member appears on the MCO's member listing in the next month. If the member is approved, and entered into the system in the last seven (7) to ten (10) days of the month, the member will appear on the plan's member listing for the following month.

ENROLLMENT PROCESS

Medicaid members receive a managed care enrollment packet or an outreach packet by mail within two days of first becoming eligible for Medicaid, and annually thirty (30) to sixty (60) days prior to their Medicaid eligibility review. Members enrolled in a MCO will also receive a reminder letter from their health plan prior to their annual Medicaid eligibility review date.

Members are always encouraged to open, read, and respond to the enrollment packets to avoid automatic MCO assignment. While managed care enrollment is encouraged during the annual

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eligibility review, FFS Medicaid beneficiaries may contact SCHCC to enroll at any time. They do not need to wait to receive enrollment information. Members enrolled in a managed care plan at the time of their annual review will remain in their MCO unless they contact SCHCC during their open enrollment (Ninety (90) day choice period) to request a change.

When enrollment packets are mailed, members have at least thirty (30) days from the mail date to choose an MCO. If a member fails to act on the initial enrollment packet, outbound calls are placed in an effort to encourage plan selection. If, after the outreach efforts, a member still fails to respond, he or she will be assigned to a MCO.

The assignment process places members into MCOs available in the county where the member resides based on the following criteria:

- The MCO, if any, in which the beneficiary was previously enrolled
- The MCO, if any, in which family members are enrolled
- The MCO is selected by a Quality Weighted Automated Assignment Algorithm process if no health plan was identified

There are three easy ways for members to enroll:

- Call SCHCC at (877) 552-4642
- Mail or fax the completed enrollment form contained in the enrollment packet
- Online at www.SCchoices.com

A member is enrolled in a Managed Care plan for a period of 12 months. The beneficiary shall remain enrolled in the MCO unless one of the following occurs:

- The member becomes ineligible for Medicaid and/or Managed Care enrollment
- The member forwards a written request to transfer plans for cause
- The member initiates the transfer process during the annual re-enrollment period
- The member requests transfer within the first ninety (90) days of enrollment

Enrollment of Newborns

Babies born to Medicaid-eligible mothers are automatically deemed Medicaid eligible. As such, they are subject to being enrolled into a MCO. If, at the time of delivery, the mother is enrolled with an MCO, the baby will be automatically enrolled into the same MCO as the mother.

Babies automatically enrolled into the mother's MCO have a ninety (90) day choice period following birth during which a change to their health plan may be made. Following the ninety (90) day choice period, the newborn enters into his or her lock-in period and may not change MCOs for the first year of life without "just cause." The newborn's effective date of enrollment into a managed care plan is the first day of the month of birth.

Providers should refer to the appropriate Medicaid provider manual for additional limitations when providing services to newborns.

MANAGED CARE SUPPLEMENT**MANAGED CARE ENROLLMENT****Primary Care Provider Selection and Assignment**

Upon enrolling into a MCO, all beneficiaries are “assigned” to a primary care provider (PCP). When the member is assigned to an MCO, the MCO is responsible for assigning the PCP. After assignment, members may elect to change their PCP. **There is no lock-in period with respect to changing PCPs.** Enrolled members may change their PCP at any time and as often as necessary.

MCO members must call their designated Member Services area with the MCO to change their PCP. The name of the designated PCP will appear on all MCO cards. Should an MCO member change his/her PCP, he/she will be issued a new card from the MCO reflecting the new PCP.

MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

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MANAGED CARE SUPPLEMENT

MANAGED CARE DISENROLLMENT PROCESS

OVERVIEW

Members not required to participate in managed care may request to disenroll and return to fee-for-service Medicaid. Members required to participate in managed care may only request to transfer to another MCO as fee-for-service Medicaid is no longer an option for the mandatory managed care population.

Disenrollment/transfer requests are processed through the enrollment broker, SCHCC. The member, the MCO or SCDHHS may initiate this process. During the 90 days following the date of initial enrollment with the MCO, beneficiaries may change plans without cause. Only one change may be requested during this period. Once a change has been requested, or the first ninety (90) days following the date of initial enrollment has expired, members move into their “lock-in” period. Requests to change MCOs during the lock-in period are processed only for “just cause.” Please refer to the MCO Policy and Procedures Guide and contract for additional information concerning just cause disenrollment requests.

Transfer requests made during the lock-in period require the completion of a Health Plan Change form, which may only be obtained by contacting SCHCC. The form requires the member to provide information confirming his or her attempt to resolve any issues necessitating disenrollment. That information includes documenting the date and time of the call to the MCO to discuss his or her issues, as well as the person with whom the member spoke. Failure to provide all required information will result in denial of the disenrollment request as all such requests must be reviewed by the SCDHHS.

Upon review by SCDHHS, the managed care plan is notified of the request to disenroll so that a plan representative may follow up with the member in an effort to address the concerns raised in the request for disenrollment. MCOs are required to notify SCDHHS within ten (10) days of the follow-up results for all complaints or disenrollment requests forwarded to the plan. If just cause is not validated, disenrollment is denied and the member remains in the managed care plan. A member’s request to transfer is honored if a decision has not been reached within sixty (60) days of the initial request. The final decision to accept the member’s request is made by SCDHHS.

If the member believes he or she was disenrolled/transferred in error, it is the member’s responsibility to contact SCHCC or the MCO for resolution. The member may be required to complete and submit a new enrollment form to SCHCC.

INVOLUNTARY BENEFICIARY DISENROLLMENT

A beneficiary may be involuntarily disenrolled from a MCO at any time deemed necessary by SCDHHS or the MCO, with SCDHHS approval.

The MCO’s request for member disenrollment must be made in writing to SCHCC using all applicable form(s), and the request must state in detail the reason for the disenrollment. The request must also include documentation verifying any change in the member’s status. SCDHHS determines if the MCO has shown good cause to disenroll the member and informs SCHCC of

MANAGED CARE SUPPLEMENT**MANAGED CARE DISENROLLMENT PROCESS**

their decision. SCHCC notifies both the MCO and the member of the decision in writing. The MCO and the member have the right to appeal any adverse decision. Providers should always check the Medicaid eligibility status of members before rendering service on the Medicaid Provider Web Tool.

The MCO may not terminate a member's enrollment because of any adverse change in the member's health. An exception would be when the member's continued enrollment in the plan would seriously impair the plan's ability to furnish services to either this particular member or other members.

For additional information, please review the involuntary disenrollment guidelines used by SCDHHS and the Managed Care plans in the **Disenrollment Process** section in the MCO Policy and Procedures Guide and contract.

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EXHIBITS

MANAGED CARE PLANS BY COUNTY

All MCOs currently contracted with SCDHHS operate statewide.

The **Exhibits** section provides the contact information and a card sample for each MCO currently operating in South Carolina.

CURRENT MEDICAID MEDICAL HOMES NETWORKS (MHNS) FOR THE MEDICALLY COMPLEX CHILDREN'S WAIVER

The following MHN participates with the Medically Complex Children's waiver and South Carolina Healthy Connections Medicaid. MHN beneficiaries should present their South Carolina Healthy Connections Medicaid Insurance card in order to receive health care services. No additional card is necessary.

South Carolina Solutions

3555 Harden St Ext. Ste. 300
Columbia, South Carolina 29203
(888) 827-1665
www.sc-solutions.org

CURRENT MEDICAID MANAGED CARE ORGANIZATIONS

South Carolina Healthy Connections Medicaid MCOs are required to issue a plan identification card to enrolled members. Members should present both the MCO-issued identification card and the Healthy Connections Medicaid card. MCO cards contain important information on the member (name, plan number), the MCO (toll-free contact numbers), and the PCP.

SAMPLE MEDICAID MCO CARDS

The following card samples are used by MCOs that are currently authorized to operate in South Carolina.

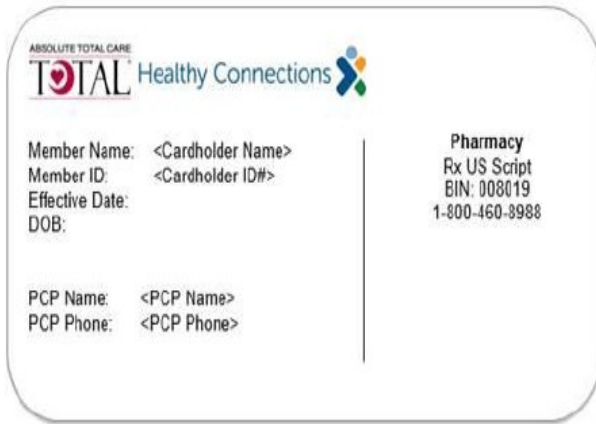
MANAGED CARE SUPPLEMENT

Absolute Total Care

Centene Corporation

(866) 433-6041

www.absolutetotalcare.com

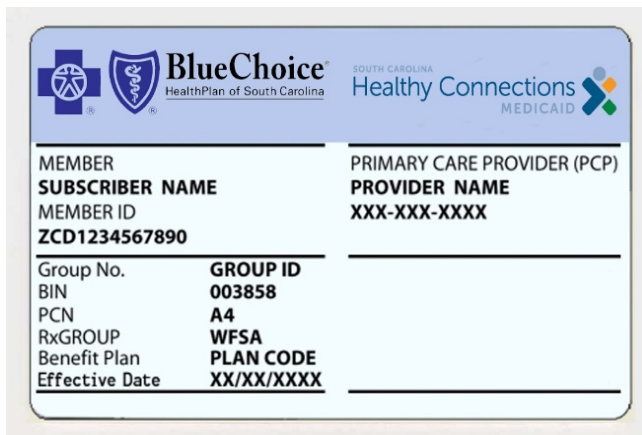


Healthy Blue by BlueChoice

BlueChoice HealthPlan of South Carolina Medicaid

(866) 781-5094

www.bluechoicesc.com



MANAGED CARE SUPPLEMENT

First Choice by Select Health

Select Health of South Carolina, Inc.
(888) 276-2020
www.selecthealthofsc.com



FirstChoice
by Select Health of South Carolina
Your Hometown Health Plan

Member Name
Healthy Connections ID **1239873200**
Sex **M** DOB **12/30/95**
Effective **11/01/12**

Healthy Connections 


Member's preferred language **Spanish**

Primary care provider (PCP) **ABC Pediatrics**
PCP Phone **843.555.1234** PCP ID **12345678**
RxBIN **600428** RxPCN **02180000**

Humana Benefit Plan of SC

1-866-432-0001

www.Humana.com



Humana
Healthy Horizons™
in South Carolina

Healthy Connections 

A Medicaid product of Humana Benefit Plan of South Carolina, Inc.

MEMBER NAME
Member ID: HXXXXXXXXX

Medicaid ID#: XXXXXXXX Group #: XXXXX
Date of Birth: XX/XX/XX RxBIN: 610649
Effective Date: XX/XX/XX RxPCN: 01391504



PCP Name: XXXXXXXXX
PCP Phone: (XXX) XXX-XXXX

MANAGED CARE SUPPLEMENT

Molina Healthcare, Inc.

1-855-882-3901

www.molinahealthcare.com



Member: John Smith

ID #: 000000111
DOB: 11/19/1963
Program: SC Medicaid

PCP Name: Dr.Carter

PCP Location: 1 MAIN ST
PCP Phone: (001) 001-0001

24hr Nurse Help Line: (888) 275-8750 or (888) 548-3537 (Expand) - Member Services (855) 882-3901

<small>RxBIN: 004336</small>	<small>RxPCN: ADV</small>	<small>RxGRP: Rx0860</small>
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