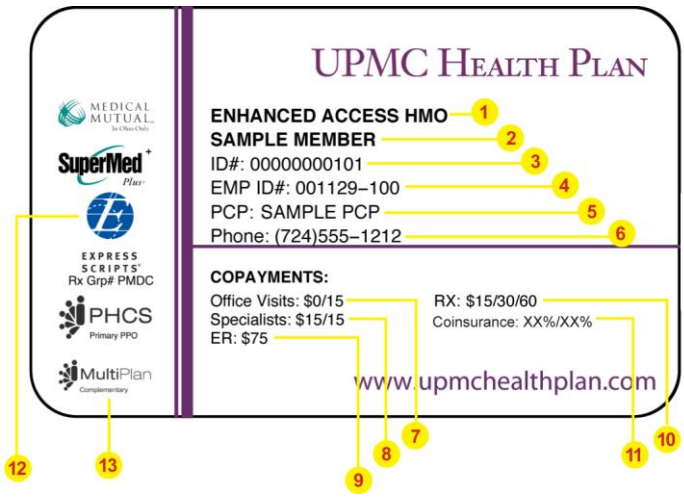
Member Administration

Member Identification Cards

The card shown below is a sample of an identification (ID) card for a typical commercial HMO or POS member or a UPMC *for Life* HMO member.

Figure I: Typical HMO/POS Member ID Card

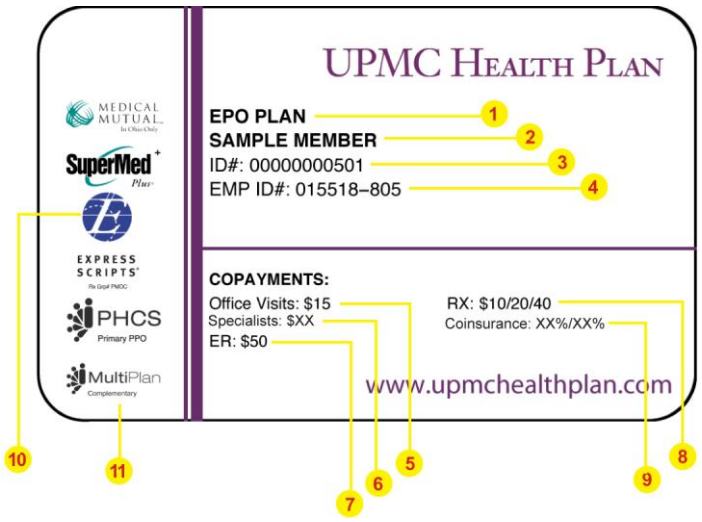


1. Plan name
2. Member name
3. Member identification number
4. Employer identification or group number
5. Primary care provider
6. Primary care provider's telephone number
7. Copayment for office visits to member's primary provider
8. Copayment for office visits other than to member's primary provider
9. Copayment for non-admitted treatment in a hospital emergency department
10. Prescription drug copayments
11. Coinsurance for services provided by network providers/coinsurance for out-of-network providers
12. Express Scripts logo indicates the member has prescription drug coverage
13. Logos indicate the member's coverage with other vendors

NOTE: If a member has a deductible, the information will be listed below the coinsurance information.

The card shown below is a sample of an identification (ID) card for a typical commercial EPO and/or PPO member.

Figure II: Typical EPO/PPO Member ID Card

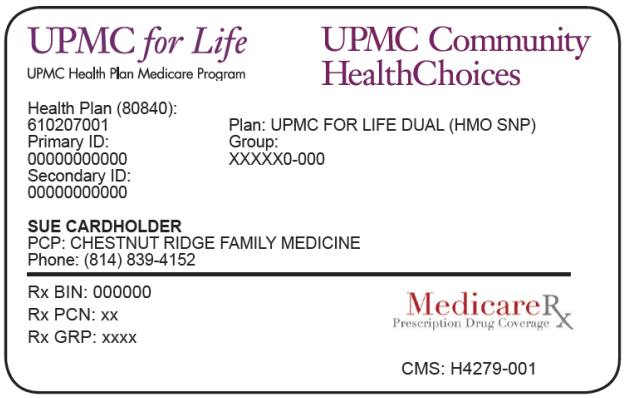


1. Plan name
2. Member name
3. Member identification number
4. Employer identification or group number
5. Copayment for office visits to member's primary provider
6. Copayment for office visits other than to member's primary provider
7. Copayment for non-admitted treatment in a hospital emergency department
8. Prescription drug copayments
9. Coinsurance for services provided by network providers/coinsurance for out-of-network providers
10. Express Scripts logo indicates the member has prescription drug coverage
11. Logos indicate the member's coverage with other vendors

NOTE: If a member has a deductible, the information will be listed below the coinsurance information.

Figure III: Typical Community HealthChoices Member ID (when UPMC Health Plan is the Medicaid and Medicare provider)

The card shown below is a sample of an identification (ID) card for a typical UPMC Community HealthChoices member who receives Medicare and Medicaid benefits from UPMC Health Plan. Please note there are two member ID numbers. Primary ID refers to Medicare benefits and Secondary ID refers to Medicaid benefits.



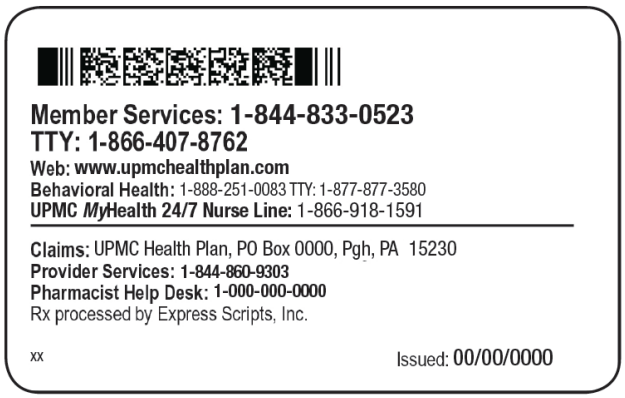
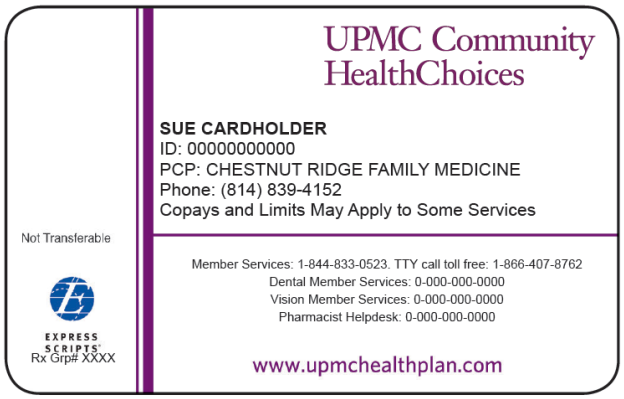


Figure IV: Typical Community HealthChoices Member ID (when UPMC Health Plan is not the Medicare provider)

The card shown below is a sample of an identification (ID) card for a typical UPMC Community HealthChoices member who receives Medicaid benefits from UPMC Health Plan. Please note that members with this card will fall into one of two groups. 1.) Members with Medicaid and Long Term Services and Supports 2.) Members with Medicare coverage with another plan but who selected UPMC Community HealthChoices for Medicaid coverage (with or without LTSS). (Group #2 may not have a PCP listed on their UPMC ID card. Inquiries related to member's PCP or Medicare benefits, should be directed to member's Medicare provider)



Provider and Member Rights and Responsibilities

UPMC Health Plan recognizes that health care and long term serices and supports (LTSS) providers have rights and responsibilities related to their work with members, other health care providers, and UPMC Health Plan. UPMC Health Plan's commitment to providers is expressed in the provider rights and responsibilities statement.

- See *Provider Rights, Responsibilities and Roles,* Provider Standards and Procedures, Chapter B.

Periodic revisions to provider rights and responsibilities are communicated via *Provider Partner Update*, which can be found on the UPMC Health Plan website at **www.upmchealthplan.com**. Paper copies of these newsletters are available by calling **Provider Services** at **1-866-918-1595**.

Member rights and responsibilities can also be found on UPMC Health Plan's website at **www.upmchealthplan.com.**

Identifying Members and Verifying Eligibility

Providers have several ways to identify a UPMC Health Plan member and verify his or her eligibility. Some of these methods are:

Member Identification Card

Each member receives an identification (ID) card with a member identification number, which can be used only by the person listed on the ID card. Use of a member's ID card by another person is insurance fraud and is grounds for the member's termination from UPMC Health Plan.

- See *Reporting Fraud and Abuse*, Provider Standards and Procedures, Chapter B.
- See *Member ID Cards*, Member Administration, Chapter I.

Enrollment forms for newborns and adopted children must be submitted within the first 31 days of life or placement. The child will receive a member ID card within 14 days after UPMC Health Plan receives the enrollment form.

Alert — Member ID Cards

Possession of a member ID card does not guarantee a member's eligibility. Providers must request any and all insurance cards from the member before performing services. Providers should verify a member's UPMC Health Plan eligibility by going to **www.upmchealthplan.com**, by calling the **Interactive Voice Response (IVR) system** at **1-866-406-8762**, or by calling **Provider Services** at **1-866-918-1595.**

Alert — Medical Assistance ACCESS Card

Possession of a green or yellow ACCESS card does not guarantee a member's eligibility. UPMC Community HealthChoices and UPMC *for You* (Medical Assistance) members may become ineligible
for Medical Assistance at any time or may request to change their Managed Care Organization at any time.

Providers must verify a member's Medical Assistance (UPMC *for You* and UPMC Community HealthChoices*)* eligibility.

Verifying Eligibility Online

UPMC Health Plan offers providers the ability to verify eligibility by going online at **www.upmchealthplan.com**. This website requires an initial registration to obtain a user ID and password. To view information about an eligible member, providers need either the member's home telephone number or member ID number. The database then reveals the member's benefits, including riders (additional benefits beyond basic coverage), and the date such benefits take effect.

UPMC Community HealthChoices members who receive Medicare and Medicaid benefits from UPMC Health Plan will have two member IDs. When verifying eligibility, providers should input both ID numbers. Medicare will be primary and Medicaid will be secondary.

Closer Look at Verifying Eligibility Online

At a minimum, providers need the following hardware and software to use the provider portion of the UPMC Health Plan website to verify eligibility:

- **Hardware**
  - Pentium class computer (500MHz) with 64 MB RAM or better
  - Video display resolution of at least 800x600 using small fonts
  - 56k modem or better (or other method for Internet connectivity)

- **Software**
  - Microsoft Windows 98SE or better
  - Microsoft Internet Explorer 5.5 with 128 bit encryption strength

To find out more about how to use UPMC Health Plan's website to verify eligibility or to set up an account, call UPMC Health Plan **Web Services** at **1-800-937-0438** from 8 a.m. to 5 p.m. Monday through Friday.

Provider Services

To verify whether a member's ID card is valid, call **Provider Services** at **1-866-918-1595**, from 8 a.m. to 5 p.m., Monday through Friday.

Providers *als*o may call the **Interactive Voice *Response* (IVR)** system at **1-866-918-1595** to verify member eligibility**.**

Chat services are available for providers from 7 a.m. to 5 p.m., Monday through Friday. The provider can log in at www.upmchealthplan.com/providers to access the chat services and follow the prompts on the screen.

For UPMC Community HealthChoices and UPMC *for You* Members Only
Providers may call the Department of Human Services (DHS) **Electronic Verification System (EVS)** at **1-800-766-5387** to determine whether the member is eligible on the date of service.

Providers may also use the DHS EVS "Swipe Box" for members who have an ACCESS card to verify eligibility. EVS machines can be obtained by calling 1-**800-248-2152.**

Alert — EVS Swipe Boxes

UPMC *for You* member identification cards do not activate DHS's EVS machines. Medical Assistance participating providers also may verify member eligibility by using DHS's online PROMISe system.

Alert — Verification of Eligibility

Checking the member eligibility report or verifying a member's eligibility does not constitute prior authorization or guarantee claim payment, nor does it confirm benefits or exclusions.

Updating Coordination of Benefits (COB) Information

When providers identify that coordination of benefits or other insurance coverage information for a member is missing or incorrect, they should notify UPMC Health Plan immediately via the website at **www.upmchealthplan.com** or contact **Provider Services** at **1-866-918-1595** from 8 a.m. to 5 p.m., Monday through Friday.

To assist with timely and accurate processing of COB claims and minimize adjustments and overpayment recoveries, UPMC Health Plan requires the following information:

- Insured ID Number
- Insured name
- Subscriber name
- Relationship to member
- Other insurance name
- Other insurance phone
- Other insurance address
- Effective date of coverage
- Term date of coverage, if applicable
- Type of coverage
  (e.g., medical, dental, auto insurance, hospital only, vision, workers' compensation, major medical, prescription, or supplemental)

Determining Primary Insurance Coverage

For UPMC Health Plan (Commercial) Members

These guidelines will help providers determine primary insurance coverage for their commercial members.

If a member is covered under two group health plans, one as the employee and the other as the spouse of an employee…
…the group health plan covering the member as a subscriber or a retiree is primary. The group health plan covering the member as a dependent is secondary.

If a member is a subscriber on more than one group health plan…
…the plan that has been active the longest is the primary health insurance carrier.

If a member has any type of Medical Assistance coverage…
…UPMC Health Plan's commercial insurance is always primary over Medical Assistance. Providers may not collect a copayment for any service, including prescriptions, when the claim is processed by the group health plan as the primary coverage. The provider is permitted to collect the Medical Assistance copayments, if applicable, for any covered service.

Any coverage from the Department of Human Services such as: Medical Assistance is always the payer of last resort. If the member has more than one commercial insurance carrier, or has Medicare and commercial insurance, or the services are EPSDT, or family planning related, other rules regarding coordination of benefits apply.

▶ See *UPMC for You* and UPMC Community HealthChoices, Member Administration, Chapter I.

If a woman has a baby…
…the newborn is covered under the mother's benefits using the mother's ID number for the first 31 days of life. If the mother does not have insurance, the baby is covered under the father's benefits, using the father's ID number, for the same period. For coverage to continue without a lapse beyond this initial period, the UPMC Health Plan subscriber (the mother or the father) must add the newborn within the first 31 days of life by submitting a completed enrollment form to the subscriber's employer. The selected primary care office for the newborn, if applicable, must be indicated on the form. For the first 31 days, if the newborn is covered under both parents, other coordination of benefits rules may apply. A child born to a Medicare Advantage member does not cover the baby for the first 31 days, but does cover delivery charges.

If a child is adopted…
…adopted children are covered automatically from the date of legal placement for 31 days. To obtain coverage for that child beyond the initial 31-day period, you must contact your employer or plan sponsor to enroll the child as a dependent before the end of the 31-day coverage period. If you do not contact your employer or plan sponsor, coverage for that child will end after the 31-day automatic coverage period.

If a child has dual coverage from both parents who are not legally separated or divorced…
…the child's primary insurance carrier is the parent or guardian whose birth date falls earlier in the calendar year. (This is known as the "birthday rule''.)

If a child has dual coverage from both parents and the parents are divorced or separated…
…the child's primary insurance carrier is the plan of the parent who has custody of the child or as indicated by court order. The secondary insurance carrier would be the plan of the spouse of the parent with custody. The tertiary insurance carrier would be the plan of the parent who does not have custody. The quaternary insurance carrier would be the plan of the spouse of the parent without custody.

Court decree exception…
…if a court decree makes the non-custodial parent responsible for the child's health care or for providing health insurance, the non-custodial parent's plan is primary.

Joint custody situations…
…if a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage, the birthday rule is followed. (Coverage is through the parent or guardian whose birthdate falls earlier in the calendar year.)

If a member is laid off or retired…
…the plan that covers a person as an employee (or that employee's dependent) who is neither laid off nor retired is primary.

If a member has UPMC Health Plan (Commercial) as secondary insurance and the primary insurance carrier authorizes coverage for a service or procedure for which UPMC Health Plan requires prior authorization…
…then UPMC Health Plan authorizations/PCP referrals are not required. If the primary carrier authorized but did not pay the service, the provider must appeal with the primary carrier. The provider must comply with all primary insurance carrier requirements for the claim to be considered by UPMC Health Plan as the secondary carrier.

If a UPMC Health Plan member is age 65 or older and is covered through current employment or a spouse's current employment and also has Medicare coverage…
…Medicare is primary if the employer has fewer than 20 employees. UPMC Health Plan is primary if the employer has 20 or more employees. Different rules may apply for certain multi-employer plans.

If a UPMC Health Plan member has Medicare due to a disability, is under age 65, and also has coverage through current employment or a family member's current employment …
…Medicare is primary if the employer has fewer than 100 employees and is not part of a multi-employer plan where any one employer has more than 100 employees. UPMC Health Plan is primary if the employer has 100 or more employees.

If a UPMC Health Plan member is also covered under Medicare because of end-stage renal disease (ESRD) …
… UPMC Health Plan is primary for the first 30 months of eligibility or entitlement to Medicare. Medicare is primary following a 30-month coordination period with a commercial health plan.

If a UPMC Health Plan member is covered under workers' compensation because of a job-related illness or injury…
…workers' compensation is primary for all workers' compensation-related services.

If a UPMC Health Plan member has been in an accident where no-fault or liability

insurance is involved…
…no-fault or liability insurance is primary for all accident-related services.

For UPMC *for Kids* (CHIP) Members

UPMC *for Kids* members cannot have additional health insurance coverage. If they are found to be active on private coverage, then CHIP coverage will be retroactively terminated to avoid an overlap in coverage (e.g. if a CHIP member obtains private insurance coverage beginning on June 1, that member would terminate from CHIP effective June 1. The member's last day of CHIP coverage would be May 31.) All UPMC *for Kids* (CHIP) premiums paid for coverage beyond the date of termination will be refunded and any claims that have been paid by UPMC *for Kids* (CHIP) must be resubmitted to the private insurance for reimbursement.

UPMC *for Kids* (CHIP) should be considered the payor of last resort. UPMC Health Plan will not pay any claims unless all other federal, state, local, or private resources available to the child are utilized first.

Retroactive terminations do not apply if the child is enrolled in Medical Assistance. UPMC *for Kids* (CHIP) coverage will be terminated at the end of the month in which UPMC *for Kids* (CHIP) is notified of the Medical Assistance enrollment.

At the time of service, providers should make reasonable efforts to obtain all information regarding other insurance from the UPMC *for Kids* member.

If a UPMC *for Kids'* (CHIP) member has a baby…
… the newborn is covered by UPMC *for Kids* for the first 31 days of life if the mother is a member of UPMC *for Kids* on the newborn's date of birth. For coverage to continue beyond this initial period, the head of the household must add the newborn to the UPMC *for Kids* coverage within the first 31 days of life by calling UPMC *for Kids* **Member Services** at **1-800-650-8762**. TTY users should call 1-800-361-2629.

If a child is adopted…
…the adoptive parent(s) must call UPMC *for Kids* Member Services and have the child added to the CHIP application. Annually, at renewal, the household will be reassessed for eligibility based on the new household size to determine the CHIP program under which the children qualify under: Free, Low-Cost, or Full-Cost coverage.

If a CHIP member has a disability…
…UPMC *for Kids* will submit the member's cases to DPW if a physician indicates on a certification form that a child is disabled for at least 12 months. Disabled children (e.g., a child with no vision) may qualify for Medical Assistance coverage and not qualify for CHIP coverage.

For UPMC *for Life* Members

Typical scenarios providers may encounter include the following:

If a UPMC *for Life* member has any type of Medical Assistance coverage…
…UPMC *for Life* is primary to the Medical Assistance coverage. Members may transfer in or out of this "dually eligible" status month to month. The provider is permitted to collect the Medical Assistance copayment, if applicable, for any service that is covered by Medical Assistance.

If a UPMC *for Life* member presents a traditional Medicare card and a UPMC *for Life* identification card…
…UPMC *for Life* is primary. Members must show both identification cards to the provider.

If a Medicare Select member presents a traditional Medicare card and a Medicare Select card…
…Medicare is primary. Members must show both identification cards to the provider.

If a UPMC *for Life* member is age 65 or older and also covered by a group health plan because of current employment or spouse's current employment…
…UPMC *for Life* is primary if the employer has fewer than 20 employees. The group health plan is primary if the employer has 20 or more employees.

If a UPMC *for Life* member is eligible for Medicare because of disability, is under age 65, and is covered by a group health plan from current employment or a family member's current employment…
…UPMC *for Life* is primary if the employer has fewer than 100 employees and is not part of a multi-employer plan where any one employer has more than 100 employees. The group health plan is primary if the employer has 100 or more employees.

If a UPMC *for Life* member is eligible for Medicare because of end-stage renal disease (ESRD) and also has group health plan coverage…
…the group health plan is primary for the first 30 months of eligibility or entitlement to Medicare. UPMC *for Life* is primary after a 30-month coordination period.

If a UPMC *for Life* member is covered under workers' compensation because of a job-related illness or injury…
…workers' compensation is primary for all workers' compensation-related services.

If a UPMC *for Life* member has been in an accident where no-fault or liability insurance is involved…
…no-fault or liability insurance is primary for all accident-related services.

Closer Look at Collection of Deductibles for All Products

Providers are prohibited from collecting Member deductibles prior to the provision of services or at the time a service is rendered. Instead, providers should bill the member for any deductibles after payment is received from UPMC Heath Plan

Closer Look at Collecting Payment

Providers may not collect a copayment from a member who has UPMC *for Life* as primary coverage and any type of Medical Assistance as secondary coverage.

The provider is permitted to collect the copayment, if applicable, for any service that is covered by Medical Assistance.

Providers also should not collect payment at the time of service from a member with Medicare Select. Instead, providers should bill the member for any deductibles or copayments after payment is received from UPMC Heath Plan.

For UPMC Community HealthChoices (UPMC CHC) and UPMC *for You* (Medical Assistance) Members

If a UPMC *for You* or UPMC CHCmember has additional health insurance coverage, UPMC *for You* or UPMC CHC is, in most cases, the payor of last resort.

UPMC *for You* acts as the primary carrier for EPSDT screens, prenatal services and services to children having medical coverage under Title IV-D Child Support Order, regardless of other coverage. If, however, these claims are received with another carrier's EOB, UPMC *for You* will coordinate benefits. UPMC CHC only covers individuals 21 years of age and older.

See *EPSDT program*, UPMC *for You (*Medical Assistance), Chapter E.

If a UPMC *for You* member has health insurance coverage from two or more policies, additional guidelines may apply as defined by each policy. Many UPMC Community HealthChoices members will have dual coverage with Medicare and Medicaid. UPMC Health Plan may or may not be the Medicare provider. Medicaid will always be the payer of last resort.

▶ See *UPMC for Health Plan (Commercial),* Member Administration, Chapter I.

▶ See *UPMC for Life (Medicare),* Member Administration, Chapter I.

If other insurance is primary, UPMC *for You* and UPMC Community HealthChoices require documentation of the other payor's payment or non-payment of the claim (e.g., the Explanation of Benefits or the Explanation of Payment).

At the time of service, providers should make reasonable efforts to obtain all information regarding other insurance from the UPMC *for You* or UPMC Community HealthChoices member.

Alert

It is a federal requirement (42 CFR 457.350) that state CHIP coverage is provided only if the child is ineligible for Medical Assistance. Any overlapping period with both CHIP and Medical Assistance coverage should be covered by Medical Assistance. In this instance, CHIP is the payor of last resort. UPMC Health Plan's CHIP product is known as UPMC *for Kids.*

▶ *For more information about the CHIP product*, see UPMC *for Kids*, Chapter D

If a woman has a baby…
…the newborn is covered by *UPMC for You* for the first 31 days of life if the mother is a member of UPMC *for You* or UPMC Community HealthChoices on the newborn's date of birth. If the mother has other primary insurance on the newborn's date of birth, the primary insurance carrier is responsible for the newborn for the first 31 days of life. For UPMC *for You* coverage to continue beyond this initial period, the mother must add the newborn to her UPMC *for You* coverage within the first 31 days of life by following the appropriate procedures established by the Department of Human Services.

If a child is adopted…
…the child is covered by UPMC *for You* for the first 31 days following legal placement with an adoptive parent who is a member of UPMC *for You* or UPMC Community HealthChoices on the day of the legal placement. The adoptive parent must add the newborn to his or her UPMC *for You* coverage within the first 31 days of legal placement by following the appropriate procedures established by the Department of Human Services.

Exceptions may apply when the child is in the custody of Children and Youth Services.

Selecting or Changing a Primary Care Provider

Selecting a Primary Care Provider (PCP)

All HMO members, including commercial, , UPMC *for You*, UPMC Community HealthChoices, UPMC *for Kids*, and UPMC *for Life*, must select a PCP. If a member does not select a PCP, UPMC Health Plan will either help the member select a PCP or assign one.

Members who have an **Enhanced Access Point-of-Service (EAPOS) plan** are encouraged to select a PCP, but they are not required to have a designated provider.

Commercial members with **Preferred Provider Organization (PPO)** and **Exclusive Provider Organization (EPO)** plans as well as **Medicare Select** and **UPMC *for Life* PPO (Medicare Advantage)** members do not select a PCP.

Changing a PCP

Commercial members who would like to change PCPs may go online to **www.upmchealthplan.com** or may contact **UPMC's Health Care Concierge Team** for assistance at the following number.

Product	Contact Information	Hours
UPMC Health Plan (Commercial)	1-888-876-2756	Monday through Friday 7 a.m. – 7 p.m. Saturday 8 a.m. – 3 p.m.

Members who belong to the following products **must** contact **UPMC's Health Care Concierge Team** to change
their PCP.

UPMC *for Kids* (CHIP)	1-800-650-8762	Monday through Friday 7 a.m. – 7 p.m. Saturday 8 a.m. – 3 p.m.
UPMC *for You* (Medical Assistance)	1-800-286-4242	Monday through Friday 7 a.m. – 7 p.m. Wednesday (extended hours) 7 a.m. – 8 p.m. Saturday 8 a.m. – 3 p.m.
UPMC *for Life* (Medicare)	1-877-539-3080	Monday through Sunday 8 a.m. – 8 p.m.* **February 15 through September 30* Monday through Friday 8 a.m. – 8 p.m. Saturday 8 a.m. – 3 p.m.
UPMC Medicare Special Needs Plans (SNP)	1-877-539-3080	Monday through Sunday 8 a.m. – 8 p.m.* **February 15 through September 30* Monday through Friday 8 a.m. – 8 p.m. Saturday 8 a.m. – 3 p.m.
UPMC Community HealthChoices	1-844-833-0523	24 hours a day, 7 days a week.

Once the request is received and processed, it takes effect immediately. The member will receive a new member ID card indicating the new PCP.
UPMC Community HealthChoices members who have Medicare coverage that is not provided by UPMC Health Plan must contact their Medicare provider to change PCPs.

Recipient Restriction Program

The Department of Human Services (DHS), UPMC Community HealthChoices and UPMC *for You* maintain a restriction program to identify and manage members who are improperly using medical services or pharmacy benefits. This program is called a Recipient Restriction Program. These members are restricted to specific PCPs, pharmacies, and/or facilities, for five years, in order to monitor utilization of services. If such a restriction applies to a member, UPMC *for You* or UPMC Community HealthChoices will send notification to that member by mail with information regarding DHS's restriction. Members or providers may request in writing that the member's designated provider(s) be changed. Within 30 days of the request UPMC *for You* or UPMC Community HealthChoices will make the requested change, which will then become effective immediately.

Written requests should be mailed to:
UPMC *for You*/UPMC CHC Recipient Restriction Coordinator P.O. Box 2968 Pittsburgh, PA 15230 Written requests can be **faxed to 412-454-2933**

A UPMC *for You* or UPMC Community HealthChoices member cannot file a complaint or grievance regarding the restriction. The UPMC *for You* or UPMC Community HealthChoices member may only appeal a restriction by requesting a DHS Fair Hearing.

Selecting a Specialist as a Member's PCP

UPMC Health Plan recognizes that in some cases a member's health care needs may be better met if the member has a specialist as a PCP. Health conditions that meet certain criteria may qualify a member for a standing referral to a specialist.

- **UPMC Health Plan (Commercial Members)**
  Commercial members who have a life-threatening, degenerative, or disabling disease or condition may contact Member Services to request that a specialist act as their PCP. If UPMC Health Plan determines that the member's condition meets the established

standards, the member will be permitted to have a specialist designated to provide and coordinate both primary and specialty care.

UPMC Community HealthChoices and UPMC *for You* (Medical Assistance) Members
Members with a life-threatening, degenerative, or disabling disease or condition may be permitted to select a specialist as their PCP. In addition, they have the option of requesting a standing referral to a specialist.

If UPMC Health Plan determines that the member's condition meets the established standards, the member will be permitted to have a specialist designated to provide and coordinate both primary and specialty care or to have a standing referral to a specialist. The member is permitted to have this specialist provide primary care and coordinate specialty care; however, the specialist must agree to these responsibilities, which include being available for emergencies 24 hours a day, 7 days a week.

The member must submit a formal request to the appropriate number listed below. UPMC Health Plan staff then contacts the specialist to see if he or she is willing to be the member's PCP. If the specialist agrees he/she must sign an agreement and go through the credentialing process again to be designated as a PCP. UPMC Health Plan will contact the specialist once the credentialing process is complete, which takes 2 to 6 months. The specialist should then inform the member that he or she is able to serve as the member's PCP.

Product	Contact Information
UPMC *for You*	Special Needs 1-866-463-1462
	Monday through Friday 7 a.m. - 8 p.m. Saturday 8 a.m. - 3 p.m.
UPMC Community HealthChoices	Health Care Concierge Team 1-844-833-0523 24 hours a day, 7 days a week

▶ See *Dual Credentialing and Re-credentialing as a PCP and Specialist,* Provider Standards and Procedures, Chapter B.

UPMC *for Kids* (CHIP) and UPMC *for Life* (Medicare Advantage) Members
A member may not select a specialist as a PCP unless that specialist is also credentialed by UPMC Health Plan as a PCP.

- See *Dual Credentialing and Re-credentialing as a PCP and Specialist,* Provider Standards and Procedures, Chapter B.

Removing a Member from a Provider's Practice

UPMC Health Plan realizes that, at times, an optimal provider-patient relationship cannot be established. If circumstances require that a provider remove a member from a practice, please follow these steps:

1. Determine why a patient should be removed from the practice.

   Complete a Patient Dismissal form which can be located at:
   www.upmchealthplan.com/docs/providers/Providers_Fax-Back-Forms.pdf#page=4

2. Draft and send letters indicating these reasons to the member and also send the patient dismissal form and letter to UPMC Health Plan.

   UPMC Health Plan*
   UPMC Health Care Concierge Department
   U.S. Steel Tower
   600 Grant Street
   Pittsburgh, PA 15219

   Please indicate on the envelope the member's applicable plan such as:
   UPMC *for Kids*
   UPMC *for Life*
   UPMC *for You*
   UPMC Community HealthChoices
   UPMC Health Plan *(Commercial)*
   UPMC *Special Needs Plan*

3. Transfer or copy the member's medical records.
   - The UPMC Health Care Concierge Team will assist the member in locating a

new provider. Providers should transfer records at no charge to the member within seven business days of being informed of the identity of the new provider.

Closer Look at Providing Care After Sending Letter

Primary care providers must provide care for 30 days from the date of the letter submitted to UPMC Health Plan.

The UPMC Health Care Concierge Team will notify the member, assist him or her in selecting a new PCP, and determine the effective date of change.