

**ELIGIBILITY, ENROLLMENT
& DISENROLLMENT
INFORMATION**



**FIRST COAST ADVANTAGE
PROVIDER INSERVICE
OCTOBER 3, 4, 5, 2007**



PLEASE RETURN VIA
FAX TO 904-244-9409

FIRST COAST ADVANTAGE EXPECTANT MOTHER NOTIFICATION FORM

Today's Date: _____
First Name of Mother: _____
Last Name of Mother: _____
Maiden Name of Mother: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Alternate Phone Number: _____
Social Security Number of Mother: _____
Medicaid ID Number of Mother: _____
Expected Due Date: _____
FCA Preauthorization Obtained? Yes No
Preauthorization # _____

Form Completed by: _____	Date: _____
Phone Number: _____	Clinic or Office Location: _____

FOR FCA OFFICE USE ONLY
Date Received: _____
Reviewed By: _____

First Coast Advantage FCA Disenrollment Process

This document will serve as a guideline to help make decisions on disenrolling a member from First Coast Advantage (FCA). A Member may submit to the Agency (Choice Counseling) or Agent (FCA) a request to disenroll without Cause during the ninety (90) Calendar Day change period following the date of the Member's initial Enrollment. A member may also request Disenrollment with Cause every twelve (12) months thereafter.

To request disenrollment on a FCA member, please complete a FCA Disenrollment form. This form will be periodically updated and can be found on the FCA website at:

www.firstcoastadvantage.com

All fields must be completed before disenrollment occurs. Please complete a form on each member you want to disenroll. You may either Fax the form to: 244-9409 attn: Disenrollment Specialist or you may drop the form off at the FCA offices located on the 10th floor of Tower II.

Please remember the following **IMPORTANT** guidelines:

1. If the member has moved, verify on the Duval County Zip Code list that the new zip code is **NOT** on the list and complete the disenrollment form to remove member from plan. The list of Duval county Zip codes can be found on the FCA website.
2. If the member expired, AHCA requires that we send the date of expiration.
3. If the member is ineligible for the plan, AHCA requires we tell them the reason they are ineligible. Please list the reason on the disenrollment request. (For list of ineligibles see page 2).
4. If a member has fraudulently used an Enrollee or Medicaid ID card, FCA will need to provide a copy of the ID card for proof of fraud. Please attach the copy to the disenrollment form.
5. If a member does not comply with the recommended plan of care, AHCA requires that we notify the member in writing that they are non-compliant. Please attach a copy of the letter with the disenrollment request.
6. If a members behavior stops FCA from providing services, FCA can request an involuntary disenrollment to the Agency (AHCA) after providing to the Member at least one (1) verbal warning and at least one (1) written warning of the full implications of his/her failure of actions. Please attach all documentation to the disenrollment request to FCA.
7. If a member has Third Party Insurance through another carrier, please attach to the disenrollment request:
 - a. Beneficiary's Name
 - b. Beneficiary's Medicaid Number
 - c. Third Party Insurance Company Name
 - d. Third Party Insurance Phone Number
 - e. Third Party Insurance Policy Number
 - f. Policy Holder's Name
 - g. Date coverage began

Please attach a copy of the members Third Party Insurance Card to the disenrollment form as backup for AHCA.

Ineligible Populations

1. Medicaid Recipients who are members of the Florida Assertive Community Treatment Team (FACT Team)
2. Pregnant women who have not enrolled in Medicaid Reform prior to the effective date of their SOBRA eligibility
3. Medicaid Recipients who, at the time of application for Enrollment and/or at the time of Enrollment, are domiciled or residing in an institution, **including nursing facilities (and have been CARES assessed)**, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an Intermediate Care Facility/Developmentally Disabled (ICF-DD)
4. Medicaid Recipients whose Medicaid eligibility was determined through the medically needy program
5. Qualified Medicare Beneficiaries ("QMBs"), Special Low Income Medicare Beneficiaries (SLMBs), or Qualified Individuals at Level 1 (QI-1s)
6. Medicaid Recipients who have other creditable health-care coverage, such as TriCare or a private health maintenance organization (HMO)
7. Medicaid Recipients who reside in the following:
 - A. Residential commitment programs/facilities operated through the Department of Juvenile Justice (DJJ)
 - B. Residential group care operated by the Family Safety & Preservation Program of the DCF
 - C. Children's residential treatment facilities purchased through the Substance Abuse & Mental Health District ("SAMH") Offices of the DCF (also referred to as Purchased Residential Treatment Services - "PRTS")
 - D. SAMH residential treatment facilities licensed as Level I and Level II facilities
 - E. Residential Level I and Level II substance abuse treatment programs
8. Medicaid Recipients participating in the Family Planning waiver
9. Participants in the Sub-acute Inpatient Psychiatric Program ("SIPP")
10. Title XXI-funded children with chronic conditions who are enrolled in Children's Medical Services Network
11. Women eligible for Medicaid due to breast and/or cervical cancer
12. Individuals eligible under a **hospice**-related eligibility group



PLEASE FAX
TO 904-244-9409

MEMBER DISENROLLMENT FORM
(ALL FIELDS MUST BE COMPLETED BEFORE DISENROLLMENT OCCURS)

Today's Date: _____
Members Last Name: _____ Members First Name: _____
Date of Birth: _____ Medicaid ID Number: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Member Home Phone: _____ Member Alternate Phone: _____

Reason for Disenrollment (Select One):

- Member moved out of Duval County service area
New address: _____

- Member death (Date of expiration _____)
- Member ineligible for plan enrollment (Reason _____)
(See FCA Disenrollment guidelines for list of ineligible recipients)
- Fraudulent Use of Member ID card
(Provide ID card for proof of fraud)
- Member does not comply with recommended plan of care (Reason _____)
- Member's behavior stops plan from giving service
- Other Insurance is Primary
Beneficiary's Name: _____
Beneficiary's Plan ID Number: _____
Third Party Insurance Company Name: _____
Third Party Insurance Phone Number: _____
Third Party Insurance Policy Number: _____
Policy Holder's Name: _____
Coverage Effective Date: _____
(Please include proof of other insurance – Medifax or copy of ID card)

Person who is completing this form: _____
Phone number: _____ Date completed: _____
Clinic or Office Location: _____

FOR FCA OFFICE USE ONLY:

Date added to disenrollment report: _____ Date letter sent to Member: _____
Disenrolled as of: _____

ZIP Codes serving the county of
Duval County

ZIP Code	City
32009	BRYCEVILLE
32073	ORANGE PARK
32099	JACKSONVILLE
32201	JACKSONVILLE
32202	JACKSONVILLE
32203	JACKSONVILLE
32204	JACKSONVILLE
32205	JACKSONVILLE
32206	JACKSONVILLE
32207	JACKSONVILLE
32208	JACKSONVILLE
32209	JACKSONVILLE
32210	JACKSONVILLE
32211	JACKSONVILLE
32212	JACKSONVILLE
32214	JACKSONVILLE
32215	JACKSONVILLE
32216	JACKSONVILLE
32217	JACKSONVILLE
32218	JACKSONVILLE
32219	JACKSONVILLE
32220	JACKSONVILLE
32221	JACKSONVILLE
32222	JACKSONVILLE
32223	JACKSONVILLE
32224	JACKSONVILLE
32225	JACKSONVILLE
32226	JACKSONVILLE
32227	JACKSONVILLE

ZIP Code	City
32228	JACKSONVILLE
32229	JACKSONVILLE
32231	JACKSONVILLE
32232	JACKSONVILLE
32233	ATLANTIC BEACH
32234	JACKSONVILLE (Baldwin)
32235	JACKSONVILLE
32236	JACKSONVILLE
32237	JACKSONVILLE
32238	JACKSONVILLE
32239	JACKSONVILLE
32240	JACKSONVILLE BEACH
32241	JACKSONVILLE
32244	JACKSONVILLE
32245	JACKSONVILLE
32246	JACKSONVILLE
32247	JACKSONVILLE
32250	JACKSONVILLE BEACH
32254	JACKSONVILLE
32255	JACKSONVILLE (Mandarin)
32256	JACKSONVILLE (Bayard)
32257	JACKSONVILLE
32258	JACKSONVILLE
32266	NEPTUNE BEACH
32267	JACKSONVILLE
32277	JACKSONVILLE

