Out of Network Policy

Medical Services

You will have to choose one of our network providers to be your Primary Care Physician (PCP). Your PCP focuses on all your healthcare needs, integrates care across all specialties and healthcare settings, and focuses on wellness and prevention. With a few exceptions, such as using a direct access services for yearly screening mammograms, you may need to obtain prior approval from your PCP before seeing a specialist. This process is called obtaining a “referral”. Our “network providers” have agreed to provide you with your health care coverage. You may go to any of our network providers; however, some services may require a referral. It’s important that you follow the plan’s rules in obtaining prior approval for services when required. If you have been seeing one network provider, you are not required to continue going to that same provider. If your doctor/other health care provider leaves the plan, your plan will notify you and you may choose another doctor from within the network.

You are always covered for emergencies. If you have an emergency, call 911 or go to the nearest emergency room. You do not need the Plan’s or your PCP’s approval before getting emergency care and you are not required to use network hospitals or doctors when seeking emergency care. If you are out of the area when you have an emergency, go to the nearest emergency room and all emergency care and post-stabilization care at the out-of-network provider will be covered. After your emergency room visit or as soon as is reasonably possible, please call your PCP and the Plan. Your PCP can coordinate or provide follow-up care that you may require after your emergency room visit. For urgent care, you must use plan providers when in the service area.

Please keep in mind that you must get your care and services from network providers except in emergency, out of area urgent care situations or out-of-area renal dialysis. If you obtain routine care from out-of-network providers neither Medicare nor the Plan will be responsible for the costs.

If you should receive a bill directly from an out-of-network provider, you should not pay the bill. Send the bill to the Plan for processing. The Plan will determine any copays or coinsurance that you are responsible for, if any. If approved, we will pay the Plan’s share of cost or send you a notice in case of denial to let you know why we may have determined the service you received was not covered. The notice will include your appeal rights. Please send your bill to:

Freedom Health, Inc.

P.O. Box 151348
Tampa, FL 33684

For more information, please refer to your Evidence of Coverage (EOC) or contact our Member Services Department at 1-800-401-2740, TTY/TDD 711.

You must submit your Claim to us within 12 months of the date you receive the service, item or Part B Drug. Contact Member Services if you have any questions. If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

Medical Coverage
Freedom Health, Inc.
P.O. Box 151348
Tampa, FL 33684

Out of Network Policy

Pharmacy Services

The Plan has a vast number of in-network pharmacies for prescription drug coverage. To see if an in-network pharmacy is available out-of-network, you may contact our Member Services Department at 1-888-407-9977, TTY/TDD 711.

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your Part D (prescription drug) claim to us within 36 months** of the date you received the drug. Mail your request for payment together with any bills or receipts to us at this address:

Freedom Health, Inc.
2240 Belleair Rd. Ste. 250
Clearwater, FL 33764