providerNEWS

A Newsletter for **Freedom Health** & **Optimum HealthCare** Providers

WINTER **2021**

Care Coordination Between Medical and Behavioral Healthcare

Enhancing Patient Doctor

Loneliness and the Holidays

AND **much more!**

Printed and mailed 12/16/2021

BEHAVIORAL HEALTH CARE TOOLS to Assist in Sharing Information

We routinely collaborate with Beacon Health Options, our Health Plan's Behavioral Health vendor, to identify, facilitate and assess continuity & coordination between medical care and behavioral healthcare providers. Through that collaboration, we wanted to share the following resources that provide details and release of information tools that may help you in facilitating the exchange of information with our members:

- Behavioral Health Provider Handbook and
- Web based PCP Toolkit

The Beacon Health Options Provider Handbook is posted on Beacon's website, **https://www.beaconhealthoptions.com/providers/beacon/handbook/** and the PCP Toolkit can be accessed through **http://pcptoolkit.beaconhealthoptions.com**. Along with Beacon Health Options, we strongly encourage Primary Care Providers, Specialists and behavioral health providers to share relevant information regarding diagnoses, medication, and/or treatment to help improve health outcomes and continuously deliver quality care to our members. You can help facilitate this sharing of information by asking our members who see a Beacon Health provider to fill out a Release of Information form (available in the PCP Toolkit) to give to that provider, allowing the sharing of updates with you.

Beta Blockers

If your patient was recently diagnosed with a heart condition like heart failure or irregular heart rhythm, or was in the hospital for a cardiac related event, you may have prescribed a beta blocker. For many people the addition of a new medication is an upsetting event. Your patient may be afraid to ask questions about the medication and why it is being prescribed.

It is important to acknowledge that not all patients have the capacity to understand the benefits of beta blocker therapy. They may be turned off by the possible side effects and choose to not take the medication. Providing additional education as to why they need the medication may be helpful in increasing compliance.

Since side effects associated with beta blockers may lead to patient non-compliance, you may not discover this until the follow-up visit. Providing your patient with a drug that is well-tolerated can lead to increased compliance and improved outcomes.

The cost of the medication is also a factor to take into consideration. Many patients live on fixed incomes and may have trouble affording a brand name medication. Propranolol ER, Propranolol, Metoprolol/Hydrochlorothiazide, Metoprolol Succinate, Metoprolol Tartrate, Metoprolol, Carvedilol ER, Carvedilol, and Atenolol are all available as a TIER I medication at no cost to the patient.

CARE COORDINATION between
Medical and Behavioral Healthcare Providers

Undeniably, communicating with patients is essential to establishing lasting relationships with them and enhancing quality of care. At the same time, patients often have multiple specialty providers; as the PCP, you are overseeing and communicating with these specialists and they with you. This is vital for excellent care.

When providers exchange information about a patient, it can flesh out the treatment plan and decrease the chance of medical errors, complications, duplicate diagnostic testing and unnecessary emergency room visits. It can give providers a more expansive view of the patient to enable effective interventions. This is especially true if the patient is seeing a behavioral health provider, whether a psychiatrist, a psychologist or a counselor.

We strongly encourage you, as the head of the Medical Home, to request your patients – our members – to ask their behavioral health providers to share records with you. In order to do this, each patient who sees a behavioral health provider would need to complete a Release of Information Form and present it to that provider. As information is exchanged, you can document it in the medical record.

Shared information is essential to good care; thank you for encouraging information exchange in the interests of helping patients attain and maintain optimal health.

CREDENTIALING

CORNER

The plan accepts CAQH Proview Credentialing applications.

The plan sends notification of re-credentialing by mail four months in advance of a providers scheduled re-credentialing due date.

When logging into the CAQH ProView Provider System to update or re-attest to your information, please review the informational banners used by CAQH to announce system updates and be sure to review the monthly ProView updates CAQH sends out via email.

Also, please continue to keep your credentialing application and attached documentation current in the CAQH ProView database including the "Release and Attestation" form.

The following items are of much importance in the credentialing process:

- **State Medical License(s) please include expiration date(s)**
- **DEA Certificate**
- **Valid Insurance Information**
- **Practice locations**
- **Hospital Admitting privileges OR if you are a PCP and you do not have hospital admitting privileges please ensure the Hospital Admitting Arrangements Supplemental Form is fully completed**
- **Questionnaire responses and explanations as required.**

Thank you for your timely submission!

……..one more reminder, please promptly notify us of any changes to your credentials.

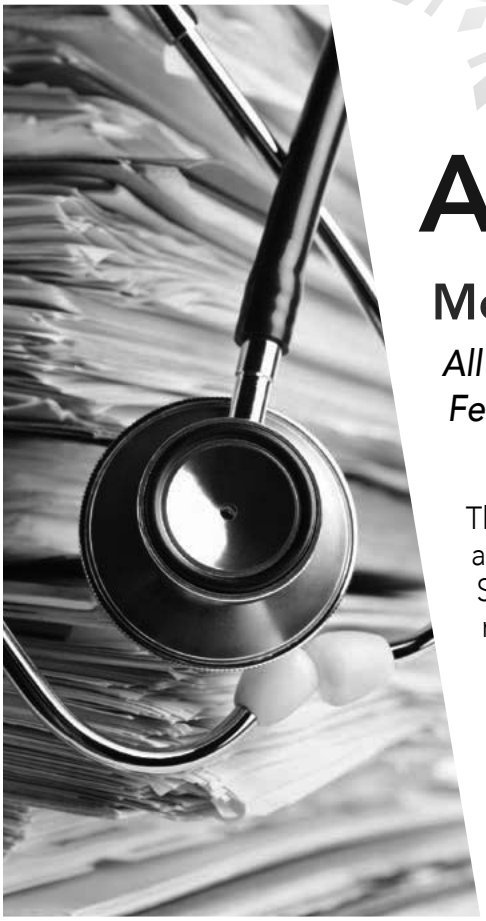
For Providers Not Part of CAQH Proview:

The notification cover letter specifies the steps along with the Plan application which needs to be completed and returned; and a list of documents needed for re-credentialing as well as the deadline for the submission. **Maintaining Active provider status is dependent upon completion of the re-credentialing process prior to the expiration date.**

Diabetic Testing SUPPLIES

As a reminder, the Plan offers Diabetic care supplies available for purchase through the member's OTC benefit. Most Plan options include an OTC allotment, amounts vary by plan type, that the member can use to purchase supplies. The Plan has added additional items into the OTC catalog for member purchase including items related to the care of diabetes.

Reminding your patient to review their Plan benefits can be very helpful in promoting good health and can help them save money. The Plan also offers Silver Sneakers as a free benefit across all Plan options. Members just need to call Member Services at the number on the back of their member ID card to inquire and learn more about their benefits.



A Reminder ABOUT

Medical Record Standards

All of Our Members Benefit from the Safeguards Established by Federal and State Guidelines

The Plan strives to provide the best quality of care to its members and expects all providers who service our members to adhere to stringent Federal and State standards regarding documentation, confidentiality, maintenance and release of medical records, as well as personal health information (PHI). The Plan's Provider Manual describes the medical record standards required for contracted providers. As a reminder, ALL providers must follow these standards and cooperate with the Plan in activities related to quality assurance monitoring of medical records. Meeting these requirements applies to both electronic and paper medical record.

ENHANCING PATIENT-DOCTOR COMMUNICATION

One of the essential factors in achieving patient-centered care is good physician-patient communication, this is one element that should not be overlooked. There are many suggestions such as maintaining eye contact as well as taking slowly, clearly and less often. You can also use the Teach-Back and Ask Me 3 Methods. The Teach-Back method is when you ask the patient to explain in their own words the information you gave them. This method demonstrates understanding and comprehension of the information the patient received. It also lets the patient take an active role in their care and lets the physician assess health literacy and understanding which ultimately helps improve health outcomes.

The Ask Me 3 Method encourages patients to ask 3 questions:

1.) What is my main problem?
2.) What do I need to do?
3.) Why is it important for me to do this?

While it may not be customary, you can improve patient-physician communication by sharing your patient's medical notes with them. When patients can read their medical notes, it fosters patient engagement. Ultimately, when patients are more actively involved in their care, it enhances their care experiences, builds trust between the physician and patient, and improves their satisfaction.

Also, if a patient can read what is on the chart, he or she will have the opportunity to correct any mistakes or add other helpful details, thereby preventing medical errors. Notes-sharing also counts towards the Meaningful Use Stage 1 requirement of providing patients with an electronic copy of their health information, and the Stage 2 requirement of providing clinical summaries for patients for each office visit.

While there are many platforms for sharing notes with patients, such as the OpenNotes project, physicians don't need to implement a formal electronic program to join this movement towards transparency and patient engagement. Physicians can start engaging their patients today just by letting them look at their records during their regular appointments. It's a simple gesture with surprisingly beneficial results.

Welcome Home: Member Engagement with the Patient-Centered Medical Home

For Primary Care Physicians, the Patient-Centered Medical Home (PCMH) represents a philosophy of providing coordinated, comprehensive care that is patient-centric and team-based. As the American College of Physicians notes, the PCMH "is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand." The Plan embraces this philosophy.

The PCMH philosophy means our members will receive safe, quality care, including services and treatment plans which address their unique health concerns and goals. The PCMH includes medication reconciliation, coaching and education to help members meet these goals.

Additional benefits of the Medical Home model include:

- a reduction in emergency department visits;
- decreased delays in members seeking treatment;
- closer management of chronic diseases;
- improved communication with patients regarding their role in the plan of care.

It is important that members understand how to directly communicate with the PCP's office. They sometimes ask the Plan to intercede with the PCP on their behalf, which causes fragmentation and delays in care. Members should have a copy of the plan of care and know who to call with questions. To maximize the effectiveness of the Medical Home, the PCP office should inform members from the outset of expectations on both sides.

- **Medication review helps members understand the medications they are taking and how they are affected by taking or not taking them.**
- **A personalized plan of care allows for mutual goal setting and evaluation of progress to goals by the provider and the member.**
- **Coaching and education focus on the information members need to manage their unique health care needs. Team support such as community resources, Plan social work or case management staff, and family support systems can provide the added connection needed to help members continue to strive to meet their health care goals.**

Provider can contact the Case and Disease Management department to refer members for assistance. Qualified staff members are available to support members who need extra coaching and support related to their chronic condition or current treatment plan. Referrals can be sent to the department via fax at 1-888-314-0794 or by calling 1-888-211-9913.

Mental and Behavioral Health

Primary Care Providers (PCPs) are on the front line when it comes to identifying and treating behavioral health issues. Many members experiencing depression are managed at the Primary Care level. It is estimated that 60 percent of the mental health issues seen in primary care are related to depressive disorders and half of patients seen have psychiatric symptoms. Depression is a treatable illness.

Mental and Behavioral Health

As the plan's provider, Beacon Health Options (Beacon), does not provide direct care. As a managed behavioral health care organization, Beacon manages a network of:

- Psychiatrists
- Doctorate prepared licensed psychologists
- Master's prepared licensed clinicians
- Day treatment programs
- Inpatient Treatment Programs
- Residential Programs
- Partial Hospitalization Programs

PCP Toolkit

Delivering mental health services in primary care settings reduces stigma and discrimination. Beacon offers PCPs a toolkit to help with the identification and next steps in the treatment of BH conditions. Beacon is committed to supporting the integration of medical and BH services with the goal of improved outcomes. The PCP toolkit offers screening and evaluation tools for ADHD, anxiety, depression, postpartum, depression, substance use and more. Those resources can be found here: Beacon PCP Toolkit (beaconhealthoptions.com)

Telehealth during Covid-19

With many members staying home in order to prevent community spread of coronavirus, telehealth has become an additional modality for providing care during this time of crisis. Telehealth allows the member to receive much needed behavioral services in a safe and secure environment. Beacon offers a wide network of telehealth resources for members and PCPs. PCP resources can be found on Beacon's website at Provider Resources | Beacon Health Options – good tools such as navigating the return to in-person school/events/work. Freedom Health members can call Beacon to receive a listing of telehealth referrals in their city at 888-273-3710.

Communicating With The PCP

Each network psychiatrist and psychotherapist is required to seek consent to release confidential information from the member. They must obtain the patient's or authorized legal representative's signed and dated consent before communicating with the patient's PCP regarding their behavioral health treatment. Encourage your patient to sign a release located in the Beacon provider toolkit.

Beacon Case Management

Beacon offers members with mild to complex or high-risk behavioral conditions the enhanced service of case management (CM). Case management supports the coordination of care and services to members who need help navigating the health care system.

Referring to Beacon Health Options

You may determine that a member can benefit from the coordination of services that Beacon's case management can provide. It can be as easy as helping a member get the appropriate referral to a BH service or more complex cases. Potential situations where a referral to Beacon CM can help:

- A member has symptoms of clinical depression and follow-up is indicated for BH services or help knowing what services are available.
- A member could benefit from therapy to deal with acute or ongoing stressors.
- A member requires evaluation for an acute, non-life-threatening crisis.
- A member is diagnosed with a severe and persistent mental illness (SMI) which requires ongoing monitoring and treatment.
- The member shows signs or symptoms of an eating disorder.
- The member requests an evaluation for substance use.

To make a referral to a Beacon licensed behavioral health clinician please email: Beacon_CM@BeaconHealthOptions.com

Other provider resources for behavioral services can be found on Beacon's website at **https://providertoolkit.beaconhealthoptions.com/**

PARTNER WITH CASE AND DISEASE MANAGEMENT NURSES

THE PLAN'S CASE AND DISEASE MANAGERS and Social Workers can collaborate with you to help provide each member the services they need to better manage their health or plan of care. Physicians and providers can refer a patient to one of our programs with just a phone call or written referral. Our overall goal is to support the member's success in implementing his or her plan of care. The referral form can be found on the Plan's website or in your Provider Manual.

DISEASE CASE MANAGERS CAN OFFER education and coaching programs for members based on chronic conditions such as Diabetes and Cardiovascular Disease. These programs are built around national evidence-based guidelines. The focus is on preventing complications and/or exacerbations, enhancing self-management and reducing acute episodes.

COMPLEX CASE MANAGERS CAN ASSIST members with urgent or acute events and coordination of services. The goal is to enhance coping and problem-solving capabilities, assist in appropriate self-direction, support proper and timely needed services and reduce readmissions.

SOCIAL WORKERS SUPPORT IS INTEGRATED into our Case and Disease Management program. Our Social Workers work in conjunction with our Nurses in identifying health and community resources which might benefit the member.

MEMBERS ENROLLED IN CASE OR DISEASE MANAGEMENT and their physicians receive ongoing support from Nurses on staff. Members may choose not to participate in the program at any time and it does not affect their benefits.

MANY TIMES, NURSES OR Social Workers will need to engage the PCP to resolve member concerns or issues. We appreciate providers supporting Member participation in these programs as a collaborative effort to maximize health and wellbeing. The Nurse or Social Worker, along with the member, develop a care plan which they send to the PCP, highlighting mutually agreed upon goals and interventions. They provide updates to the care plan when initiatives change.

OUR NURSES AND SOCIAL WORKERS also remind members who see Behavioral Health providers to fill out a Release of Information form, giving those providers permission to share information with the PCP. You can facilitate this process by providing members with a copy of the form, which is in the Beacon Health provider toolkit (https://providertoolkit.beaconhealthoptions.com/).

Thank you for all you do to help keep the channels of communication open and to provide the best care for our members!

CONTACT

Call us toll-free at 1-888-211-9913
from 8:00 a.m. to 4:00 p.m. Monday through Friday.

To access the referral form on the internet visit the Plan website and follow this path: **Providers -> Tools and Resources -> Case/Disease**

A Perfect Storm: Loneliness, the Pandemic and the Holidays

The winter holidays are upon us, a time of year which can be emotionally challenging for patients without supportive families or friends. This year, as covid-19 persists, your patients' stressors may be heightened due to fear of infection, resulting in continued social distancing, and isolation. Even virtual human interaction may be difficult or unavailable for those without the resources or family and friends to help form an online community.

Your patients may be struggling with loneliness, sadness and thoughts of suicide. Many patients regard their PCPs as trusted friends and confidants, with whom they can discuss their feelings. While not all are openly forthcoming about how they are feeling, many are willing to share if asked. Please take time to ask your patients how they're doing emotionally.

The Health Plan also has nurse Case Managers and Social Workers who can offer a friendly voice and listening ear to your patients. They can help connect folks with behavioral health services, community services and support groups. We encourage you, as the PCP, to reach out to the Plan so we can get in touch with your neediest patients. Patients may also self-refer via the Member Portal or by calling the Member Services number on the back of the Plan I.D. card and asking for Case Management or Social Services.

Please consider posting in your office the **National Suicide Prevention Lifeline, 1-800-273-8255.** The National Suicide Prevention Lifeline is staffed 24 hours a day, every day. Sometimes just one conversation can change a life.

Your Role in Care Transition Support

Do you know when one of your patients is admitted to a hospital?

Our Health Plan is making a renewed effort to identify gaps in treatment and proactively resolve issues for members after a hospital stay. The goal is to remove barriers that prevent the member's plan of treatment from being implemented, while positively affecting readmission rates.

Did you know the Health Plan's staff makes Discharge Support calls to members shortly after their discharge?

Discharge support calls help us identify members who may be at risk for readmission. Our experienced staff is assessing:

- Whether discharge instructions are available and understood;
- If the member's current support mechanisms are adequate, including psychosocial barrier resolution;
- Medication compliance, e.g., prescriptions being filled and taken as prescribed; and/or
- Whether home health visits or Durable Medical Equipment have been scheduled or provided, when applicable.

How soon do you see a patient after their discharge from an acute care facility?

Members are encouraged to bring all discharge instructions to their follow-up PCP visit. If the memberhas not scheduled a follow-up appointment at the time of the Discharge Support call, the Health Plan staff facilitates the appointment scheduling with the PCP's office staff. The target is for the member to have a follow-up PCP consult within seven days post-hospitalization.

Do you have a copy of the Discharge Summary?

With the growing use of hospitalists, the discharge summary serves as a communication tool and provides the basis for continuing care especially if you don't have access to all of the member's inpatient documentation. Both CMS and Hospital accreditors require a discharge summary documenting the patient's outcome of hospitalization, disposition and provisions for follow-up care. The Discharge Summary provides valuable information regarding the member's inpatient stay, treatment and medications. Providers are encouraged to actively seek this information to provide appropriate follow-up care and prevent readmission.

In addition, if the member needs Behavioral Health follow-up, we encourage you to facilitate communication by providing the member with a Release of Information (R.O.I.) form to fill out and give to the Behavioral Health provider. That provider can then share insights and updates with you. You may find the form at **https://pcptoolkit.beaconhealthoptions.com.**

PROVIDER RELATIONS DEPARTMENT 2021

Administration

Title	Name	Office Number	Ext	E-mail
Executive Administrative Assistant	Tammy Taylor	(813) 506-6000	11377	tetaylor@freedomh.com
Director, Network Relations	Adrian Goluch	(813) 506-6000	11354	agoluch@freedomh.com
Provider Network Mgr I - Statewide Physician and Hospital Groups	Ileana Escobosa	(813) 506-6000	11953	iescobosa@freedomh.com
Provider Network Mgr I - Statewide Physician and Hospital Groups	Ken England	(813) 506-6000	11713	kengland@freedomh.com
Network Contract Administrator	Michelle Woodard	(813) 506-6000	11256	Mwoodard@freedomh.com
Provider Contract Specialist I	Lindsey Gavin	(813) 506-6000	11783	logavin@freedomh.com
Network Data Spec Ld	Bhoshile Mangru	(813) 506-6000	11117	bmangru@freedomh.com
Network Directory Spec Sr	Shawn Khurana	(813) 506-6000	11187	skhurana@freedomh.com
Network Directory Spec Sr	Arielle Lyles	(813) 506-6000	19189	Alyles@freedomh.com
Network Directory Spec Sr	Alexis Bissen	(813) 506-6000	19169	abissen@freedomh.com
Network Directory Spec Sr	Wil Reyes	(813) 506-6000	19191	Wreyes@freedomh.com
Manager I, Claims	Jacqueline Glymph - Anderson	(813) 506-6000	11085	janderson@freedomh.com
Provider Pay Reconsider Analyst I	Julissa P De La Cruz	(813) 506-6000	11087	jpdlacruz@freedomh.com
Provider Pay Reconsider Analyst I	Susie Heffner	(813) 506-6000	11329	sheffner@freedomh.com
Provider Pay Reconsider Analyst I	Teela Barr	(813) 506-6000	11355	tbarr@freedomh.com
Provider Pay Reconsider Analyst I	Ailicec Cabrera	(813) 506-6000	11294	acabrera@freedomh.com
Provider Pay Reconsider Analyst I	Lakelia Tookes	(813) 506-6000	19182	ltookes@freedomh.com
Provider Pay Reconsider Analyst I	Jose Garcia	(813) 506-6000	11467	jgarcia02@freedomh.com
Project Manager, Sr.	Marcos Vazquez	(813) 506-6000	11044	mvazquez@freedomh.com
Project Administrator	Marion Policarpio	(813) 506-6000	11975	mpolicarpio@freedomh.com
Grievance/Appeals Rep III	Ebony Baker	(813) 506-6000	11191	ebaker@freedomh.com
Grievance/Appeals Rep II	Johanna Arroyo	(813) 506-6000	11513	jarroyo@freedomh.com
Grievance/Appeals Rep I	Anthony Mckenzie	(813) 506-6000	11036	amckenzie@freedomh.com
Grievance/Appeals Rep I	Delticeer Williams	(813) 506-6000	11969	ddwilliams@freedomh.com

Ancillary

Title	Name	Office Number	Ext	E-mail
Director, Network Relations	Ken Hacek	(813) 506-6000	11037	khacek@freedomh.com
Provider Network Manager II - Home Health	Elizabeth Davis	(813) 506-6000	19321	Edavis@freedomh.com
Provider Network Manager II - DME/O&P (Team lead)	Maureen Shillingford	(813) 506-6000	11913	mshillingford@freedomh.com
Provider Network Manager II - SNF	Melanie Paulk	(813) 506-6000	11181	mpaulk@freedomh.com
Provider Contract Specialist II - In House	Kailee Hamilton	(813) 506-6000	19455	Khamilton@freedomh.com
Manager II, Provider Network Mgmt/Relations - Gym, Vision, Lab, Dental, Hearing, Trans, Chiro, Podiatry, BH	Nick Patel	(813) 506-6104	11158	npatel@freedomh.com
Network Management Rep, Sr. - Vision, Dental, Hearing, Transportation, Chiro, Podiatry	Debbie Nix	(813) 506-6000	11949	dnix@freedomh.com
Network Management Rep - Gym, Vision, Lab, Dental, Hearing, Trans, Chiro, Podiatry	Kenneth Daniels	(813) 506-6000	11417	kdaniels@freedomh.com
Provider Network Manager II - Behavioral Health	Alba Rivera	(813) 506-6000	11958	acrivera@freedomh.com
Provider Network Manager I - DME	Maureen Shillingford	(813) 506-6000	11913	mshillingford@freedomh.com
Manager II, Provider Network Mgmt/Relations - Ancillary Contracting: Dialysis, DME, IV Infusion, Out Pt. Therapy, Orthotics/Prosthetics, Urgent Care	Sheila Peglow	(813) 506-6000	11060	speglow@freedomh.com
Provider Network Manager I - IV Infusion, Urgent Care	Fatemeh Sanchez	(813) 506-6000	11553	fsanchez@freedomh.com
Provider Network Manager I - Orthotics/Prosthetics	Mary C. Young	(813) 506-6000	11456	mcyoung@freedomh.com
Provider Network Manager I - DME	Amit Bhatt	(813) 506-6000	11486	abhatt@freedomh.com
Provider Network Manager I - Dialysis	Marquessa Jefferson	(813) 506-6000	11419	mjefferson@freedomh.com
Provider Network Manager I - Out Patient Therapy	Peter Vega	(813) 506-6000	11542	Pvega@freedomh.com

West Florida

Title	Name	Office Number	Ext	E-mail
Director, Network Relations	Lisa Myers	(813) 506-6000	11110	lmyers@freedomh.com
Network Development Analyst Lead	Linda Cornell	(813) 506-6000	11104	lcornell@freedomh.com
Provider Network Manager II - PCPs in Hills County	Raquel Rosa	(813) 506-6000	11265	rrosa@freedomh.com
Provider Network Manager II - PCPs in Pasco County	Jennifer Beaton	(813) 506-6000	11272	jbeaton@freedomh.com
Provider Network Manager II - PCPs in Polk County	Aubrette Johnson	(813) 506-6000	11043	ajohnson@freedomh.com
Provider Network Manager II - PCPs in Pinellas County	Travis Nipper	(813) 506-6000	11959	tjnipper@freedomh.com
Provider Network Manager II - Specialists in Hills and Polk Counties	Ted Esteves	(813) 506-6000	11716	testeves@freedomh.com
Provider Network Manager II - Specialists in Pinellas and Pasco Counties	Harshit Patel	(813) 506-6000	11464	hpatel01@freedomh.com
Provider Contract Specialist Sr.	Dennis Samuels	(813) 506-6000	11858	dsamuels@freedomh.com
Provider Contract Specialist I	Harshida Patel	(813) 506-6000	19190	hpatel@freedomh.com
Provider Contract Specialist	Tara Fisher	(813) 506-6000	11465	tfisher@freedomh.com
Director, Network Relations - West Coast Region	Lisa Myers	(813) 506-6000	22051	lmyers@freedomh.com
Provider Network Manager I - Specialists for Citrus/Hernando	Tara Fisher	(813) 506-6000	11465	tfisher@freedomh.com
Provider Network Manager II - PCPs for Citurs/Hernando	Kristen Doherty	(813) 506-6000	22060	kdoherty@freedomh.com
Provider Contract Specialist I - In House	Lauriet Marquina	(813) 506-6000	22052	lmarquina@freedomh.com

Gulf Coast

Title	Name	Office Number	Ext	E-mail
Manager II, Provider Network Mgmt/Relations - Gulf Coast Region	Debra Howard	(813) 506-6000	22161	dehoward@freedomh.com
Provider Network Manager I - PCPs for Manatee County	Kyle Bryant	(813) 506-6000	22165	kbryant@freedomh.com
Provider Network Manager I - PCPs for Sarasota County	Latiesha Nevils	(813) 506-6000	22168	lnevils@freedomh.com
Provider Network Manager I - PCPs for Charlotte, Lee, and Collier Counties	Amber Skulina	(813) 506-6000	N/A	askulina@freedomh.com
Provider Network Manager I - Specialists for Manatee and Sarasota Counties	Caitlin Riley	(813) 506-6000	22162	criley@freedomh.com
Provider Network Manager I - PCPs for Charlotte, Lee, and Collier Counties	Amber Skulina	(813) 506-6000	N/A	askulina@freedomh.com
Provider Network Manager I - Specialists for Collier, Lee and Charlotte Counties	Mike Munzert	(813) 506-6000	N/A	mmunzert@freedomh.com

East Florida

Title	Name	Office Number	Ext	E-mail
Director Network Management - East & Central Florida Region	Michelle Molina	(407) 965-2684	22108	mmolina@freedomh.com
Manager II Provider Network Management/Relations - Lake, Marion & Sumter Counties	Patty Carrow	(352) 586-9838	N/A	pcarrow@freedomh.com
Provider Network Manager I - Specialists in Marion County	Cheryl Haley	(352) 237-2351	22006	chaley@freedomh.com
Provider Contract Specialist I	Nicholas Belen	(407) 965-2684	22118	nbelen@freedomh.com
Provider Network Manager I- PCP's in Lake & Sumter Counties	Caitlin Mercado	(407) 965-2684	22111	cmercado@freedomh.com
Provider Network Manager I- PCP's Marion County	Rochelle Randall	(352) 237-2351	22007	rrandall@freedomh.com
Provider Network Manager I- Specialists in Lake & Sumter Counties	Shannon Bethea	(352) 857-6739	N/A	sbethea@freedomh.com
Provider Network Manager I- PCP's in Lake, Marion & Sumter Counties	Racheal Larramore	(352) 237-2351	22005	rlarramore@freedomh.com
Provider Contract Specialist I	Julneh Hernandez	(352) 237-2351	22008	hernandezj@freedomh.com

Central Florida

Title	Name	Office Number	Ext	E-mail
Director Network Management - East & Central Florida Region	Michelle Molina	(407) 965-2684	22108	mmolina@freedomh.com
Network Development Analyst Ld- HEDIS/PCPs - Central Florida Region	Dawn Smith	(407) 965-2684	22114	drsmith@freedomh.com
Provider Contract Specialist	Nidia Viloria	(407) 965-2684	22109	nviloria@freedomh.com
Provider Network Mgr I - PCP/Complete Health IPA/ Specialists - Brevard and Volusia Counties	Jennifer Solano Lucas	(407) 965-2684	22117	jslucas@freedomh.com
Provider Network Mgr I - Specialists - Orange and Seminole Counties	Juanita DeJesus	(407) 965-2684	22107	Jdejesus@freedomh.com
Provider Network Mgr I - PCPs Brevard County	Phyllis Gold	(407) 965-2684	22116	pgold@freedomh.com
Provider Network Mgr I - PCPs and Specialists for Osceola County	Suhelie Rodriguez	(407) 965-2684	22106	Rodriguezs@freedomh.com
Provider Network Mgr I - PCPs - Seminole and Volusia Counties	Laude Rodriguez	(407) 965-2684	22110	lmrodriguez@freedomh.com
Provider Network Mgr I - PCPs - Volusia County	Oscar Iturrizaga	(407) 965-2684	11713	oiturrizaga@freedomh.com
Provider Network Mgr I - Specialist - Brevard, Seminole and Volusia Counties	Eric Kingsley	(407) 965-2684	19121	ekingsley@freedomh.com

South Florida

Title	Name	Office Number	Ext	E-mail
Director, Network Relations	Adrian Goluch	(813) 506-6000	11354	agoluch@freedomh.com
Provider Contract Specialst I	Angel Gonzalez	(813) 506-6000	11496	agonzalez@freedomh.com
Provider Network Mgr I - PCPs for Palm Beach	Mercedes Ortega	(813) 422-8468	N/A	Mortega@freedomh.com
Provider Network Mgr I - PCPs for Broward County	Christian Sirven	(813) 399-0131	N/A	CSirven@freedomh.com
Provider Network Mgr I - Specialists for Dade, Broward, Palm Beach, Martin, Indian River, St. Lucie	Yvette Mills	(813) 347-7522		Ymills@freedomh.com

TC

Title	Name	Office Number	Ext	E-mail
Provider Network Manager Sr. - St Lucie, Indian River, Martin County	Belkys Vargas	(561) 880-7712	N/A	bvargas@freedomh.com

FREEDOM HEALTH

OPTIMUM HealthCare, Inc.

P.O. Box 151137, Tampa, FL 33684

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WINTER 2021

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