Indian Health Service

Insurance Elements, Verification Process, Important Forms & Sequencing

FAWNIA FRANKLIN &

LESLIE BOWSTRING-REECE

MARCH 12, 2024

OBJECTIVES

- ❑ Why does IHS collect THIRD-PARTY?
- ❑ What is the revenue used for?
- ❑ How does it benefit our patients?
- ❑ Health Insurance Terms
- ❑ Types of Insurers
- ❑ Important Forms for Billing
- ❑ Insurance Verification Process
- ❑ Coordination of Benefits & Sequencing
- ❑ Prior Authorizations
- ❑ Reports

INDIAN HEALTH CARE IMPROVEMENT ACT

AN ACT To implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes.

SEC. 206. [25 U.S.C. 1621e] REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

(a) RIGHT OF RECOVERY.—Except as provided in subsection (f), the United States, an Indian tribe, or tribal organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed by the Secretary, an Indian tribe, or tribal organization in providing health services through the Service, an Indian tribe, or tribal organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if—

(1) such services had been provided by a nongovernmental provider; and

(2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

(b) LIMITATIONS ON RECOVERIES FROM STATES.—Subsection (a) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

(1) workers' compensation laws; or

(2) a no-fault automobile accident insurance plan or program.

(c) NONAPPLICABILITY OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after the date of enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States, an Indian tribe, or tribal organization under subsection (a).

(d) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States, an Indian tribe, or tribal organization to enforce the right of recovery provided under this section shall operate to deny to the injured person the recovery for that portion of the person's damage not covered hereunder.

(e) ENFORCEMENT.—

(1) IN GENERAL.—The United States, an Indian tribe, or tribal organization may enforce the right of recovery provided under subsection (a) by—

(A) intervening or joining in any civil action or proceeding brought—

(i) by the individual for whom health services were provided by the Secretary, an Indian tribe, or tribal organization; or

(ii) by any representative or heirs of such individual, or

(B) instituting a separate civil action, including a civil action for injunctive relief and other relief and including, with respect to a political subdivision or local governmental entity of a State, such an action against an official thereof.

(2) NOTICE.—All reasonable efforts shall be made to provide notice of action instituted under paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

(3) RECOVERY FROM TORTFEASORS.—

(A) IN GENERAL.—In any case in which an Indian tribe or tribal organization that is authorized or required under a compact or contract issued pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) to furnish or pay for health services to a person who is injured or suffers a disease on or after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 under circumstances that establish grounds for a claim of liability against the tortfeasor with respect to the injury or disease, the Indian tribe or tribal organization shall have a right to recover from the tortfeasor (or an insurer of the tortfeasor) the reasonable value of the health services so furnished, paid for, or to be paid for, in accordance with the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), to the same extent and under the same circumstances as the United States may recover under that Act.

(B) TREATMENT.—The right of an Indian tribe or tribal organization to recover under subparagraph (A) shall be independent of the rights of the injured or diseased person served by the Indian tribe or tribal organization.

(f) LIMITATION.—Absent specific written authorization by the governing body of an Indian tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), the United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe, tribal organization, or urban Indian organization. Where such authorization is provided, the Service may receive and expend such amounts for the provision of additional health services consistent with such authorization.

(g) COSTS AND ATTORNEY'S FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded its reasonable attorney's fees and costs of litigation.

(h) NONAPPLICABILITY OF CLAIMS FILING REQUIREMENTS.—An insurance company, health maintenance organization, self-insurance plan, managed care plan, or other health care plan or program (under the Social Security Act or otherwise) may not deny a claim for benefits submitted by the Service or by an Indian tribe or tribal organization based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act or recognized under section 1175 of such Act.

(i) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—The previous provisions of this section shall apply to urban Indian organizations with respect to populations served by such Organizations in the same manner they apply to Indian tribes and tribal organizations with respect to populations served by such Indian tribes and tribal organizations.

(j) STATUTE OF LIMITATIONS.—The provisions of section 2415 of title 28, United States Code, shall apply to all actions commenced under this section, and the references therein to the United States are deemed to include Indian tribes, tribal organizations, and urban Indian organizations.

(k) SAVINGS.—Nothing in this section shall be construed to limit any right of recovery available to the United States, an Indian tribe, or tribal organization under the provisions of any applicable, Federal, State, or tribal law, including medical lien laws.

[Public Law 94–437; Approved September 30, 1976; 25 U.S.C. 1601 et seq.]

[As Amended Through P.L. 117–58, Enacted November 15, 2021]

https://www.govinfo.gov/content/pkg/COMPS-1406/pdf/COMPS-1406.pdf

The Indian Health Service is funded each year through appropriations by the U.S. Congress.

SERVICE UNIT BENEFITS

EQUIPMENT

SUPPLIES

SERVICES

STAFF

CONTRACTORS

FACILITY NEEDS

GOVERNMENT SHUTDOWN

SAVE PURCHASED REFERRED CARE (PRC) DOLLARS

PATIENT BENEFITS

EMERGENCY TRANSPORTATION (Ambulance/Air Ambulance/GIMC Ambulance)

EMERGENCIES AT NON-IHS HOSPITALS

SERVICES OUTSIDE OF IHS

MEDICATIONS OUTSIDE OF IHS

MEDICARE ADVANTAGE PLANS – ADDITIONAL SERVICES

MEDICAID MANAGED CARE PLANS

- INCENTIVES
- NON-EMERGENCY TRANSPORTATION
- TRADITIONAL SERVICES

HEALTH INSURANCE TERMS

HEALTH PLAN– TYPE OF PLAN THAT COVERS HEALTH SERVICES – **May change annually**

TYPE OF PLAN – HMO, PPO, POS, EPO, INDEMNITY (**IN-NETWORK/OUT-OF-NETWORK BENEFITS**); DENTAL, VISION, ETC.

BENEFIT/COVERED SERVICE – DEFINES WHAT SERVICES ARE COVERED.

PREFERRED PROVIDER – A PROVIDER WHO HAS A CONTRACT WITH THE INSURANCE PLAN; IN-NETWORK

COORDINATION OF BENEFITS – SEQUENCING OF PAYERS FOR A SERVICE

HEALTH INSURANCE TERMS

CLAIM – BILL FOR SERVICES TO THE INSURANCE (ELECTRONIC OR PAPER)

MEMBER IDENTIFICATION NUMBER/POLICY NUMBER

GROUP NUMBER

POLICY HOLDER

DEPENDENT

PERSON CODE

EFFECTIVE DATE – DATE COVERAGE BEGAN FOR MEMBER OR PLAN

TIMELY FILING/FILING LIMIT – AMOUNT OF TIME YOU HAVE TO FILE A CLAIM FROM THE DATE OF SERVICE

PHARMACY BIN/PCN

PROVIDER PHONE NUMBER – NUMBER CALL FOR ELIGIBILITY AND BENEFITS

PRE-CERT/PRIOR AUTH/NOTIFICATION/UTILIZATION REVIEW PHONE NUMBER – INPATIENT, OUTPATIENT PROCEDURES, BEHAVIORAL HEALTH, RADIOLOGY SERVICES, ETC.

AUTHORIZATION – THE APPROVAL OF CARE

TERMINATION DATE – DATE COVERAGE ENDED

TYPES OF INSURERS

MEDICAID

MEDICARE

PRIVATE INSURANCE

VETERANS

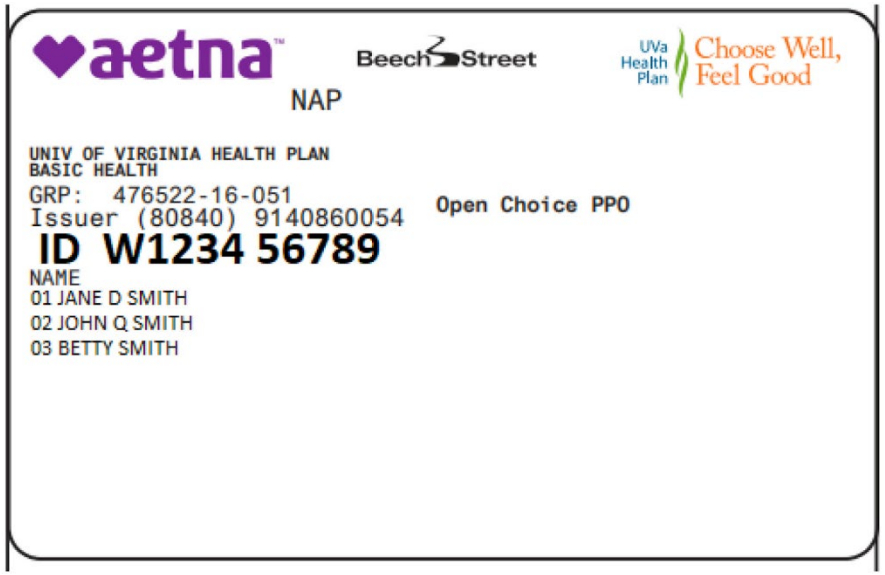
COMMISSION CORP & DEPENDENTS

WORKERS COMPENSATION

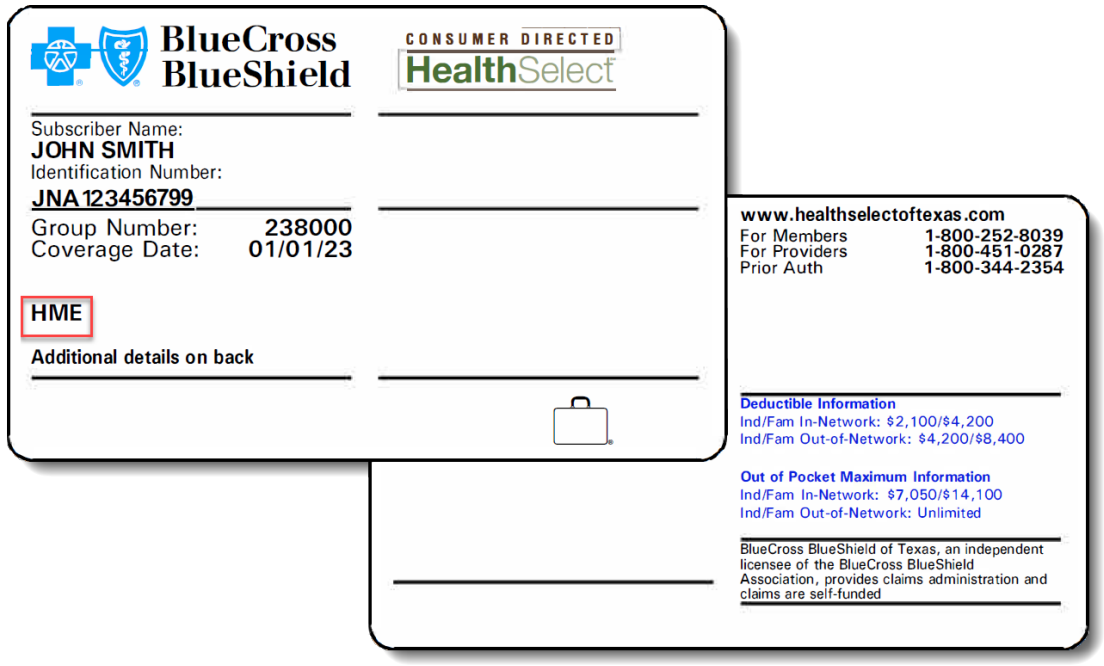
THIRD-PARTY LIABILITY

NON-BENEFICIARIES

INSURANCE CARDS



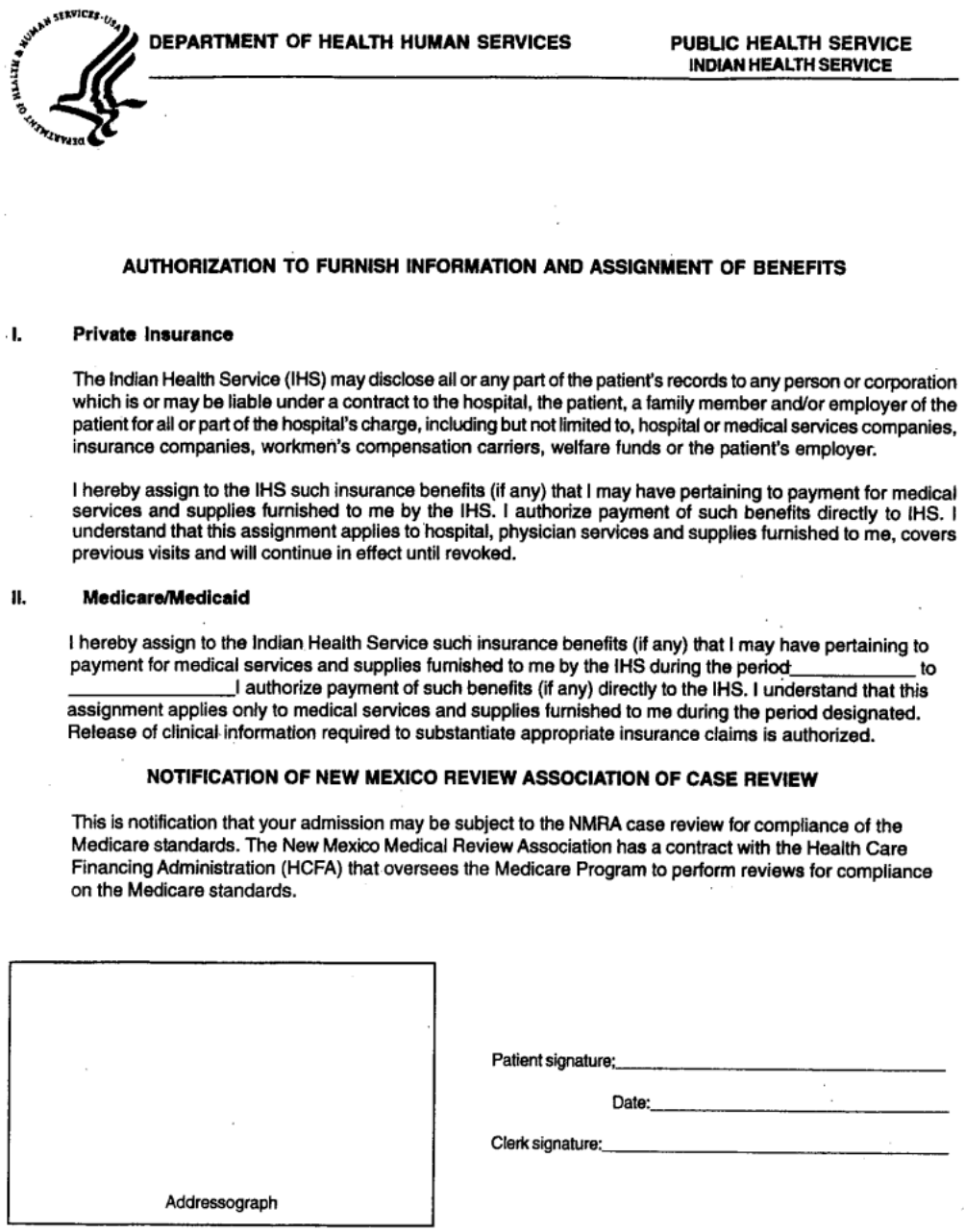
VS



AUTHORIZATION OF BENEFITS & RELEASE OF INFORMATION

An AOB is an agreement that, once signed, transfers the insurance claims rights or benefits of your insurance policy to a THIRD-PARTY. An AOB gives the THIRD-PARTY authority to file a claim, make repair decisions and collect insurance payments without your involvement.

TIP: Instead of waiting to sign the form when it's due. Get it signed for the year.



DEPARTMENT OF HEALTH HUMAN SERVICES

PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

AUTHORIZATION TO FURNISH INFORMATION AND ASSIGNMENT OF BENEFITS

I. Private Insurance

The Indian Health Service (IHS) may disclose all or any part of the patient's records to any person or corporation which is or may be liable under a contract to the hospital, the patient, a family member and/or employer of the patient for all or part of the hospital's charge, including but not limited to, hospital or medical services companies, insurance companies, workmen's compensation carriers, welfare funds or the patient's employer.

I hereby assign to the IHS such insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me by the IHS. I authorize payment of such benefits directly to IHS. I understand that this assignment applies to hospital, physician services and supplies furnished to me, covers previous visits and will continue in effect until revoked.

II. Medicare/Medicaid

I hereby assign to the Indian Health Service such insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me by the IHS during the period_____ to _____I authorize payment of such benefits (if any) directly to the IHS. I understand that this assignment applies only to medical services and supplies furnished to me during the period designated. Release of clinical information required to substantiate appropriate insurance claims is authorized.

NOTIFICATION OF NEW MEXICO REVIEW ASSOCIATION OF CASE REVIEW

This is notification that your admission may be subject to the NMRA case review for compliance of the Medicare standards. The New Mexico Medical Review Association has a contract with the Health Care Financing Administration (HCFA) that oversees the Medicare Program to perform reviews for compliance on the Medicare standards.

Addressograph

Patient signature:_____

Date:_____

Clerk signature:_____

VERIFICATION PROCESS

ONLINE PORTALS

INTERACTIVE VOICE RESPONSE

FAX BACK

CUSTOMER SERVICE

CHANGE HEALTH

- ADHOC
- CARD FINDER
  - ^PRIV
  - ^ELIG (PART D COVERAGE)

REQUIRED INFORMATION

TAX ID NUMBER

NATIONAL PROVIDER ID NUMBER (NPI)
- FACILITY
- PROVIDER

MEDICAID PROVIDER ID NUMBERS

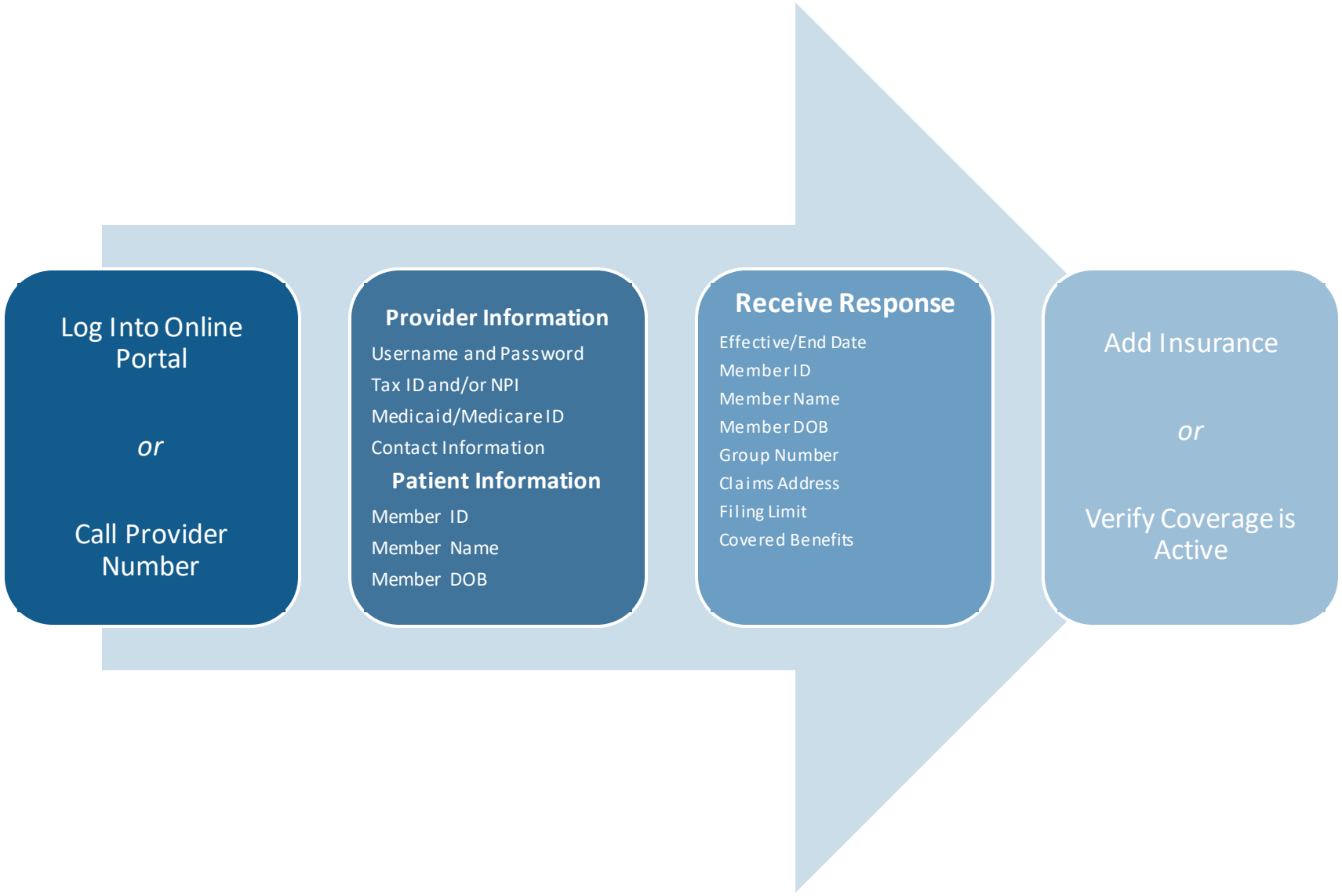
MEDICARE PROVIDER ID NUMBERS

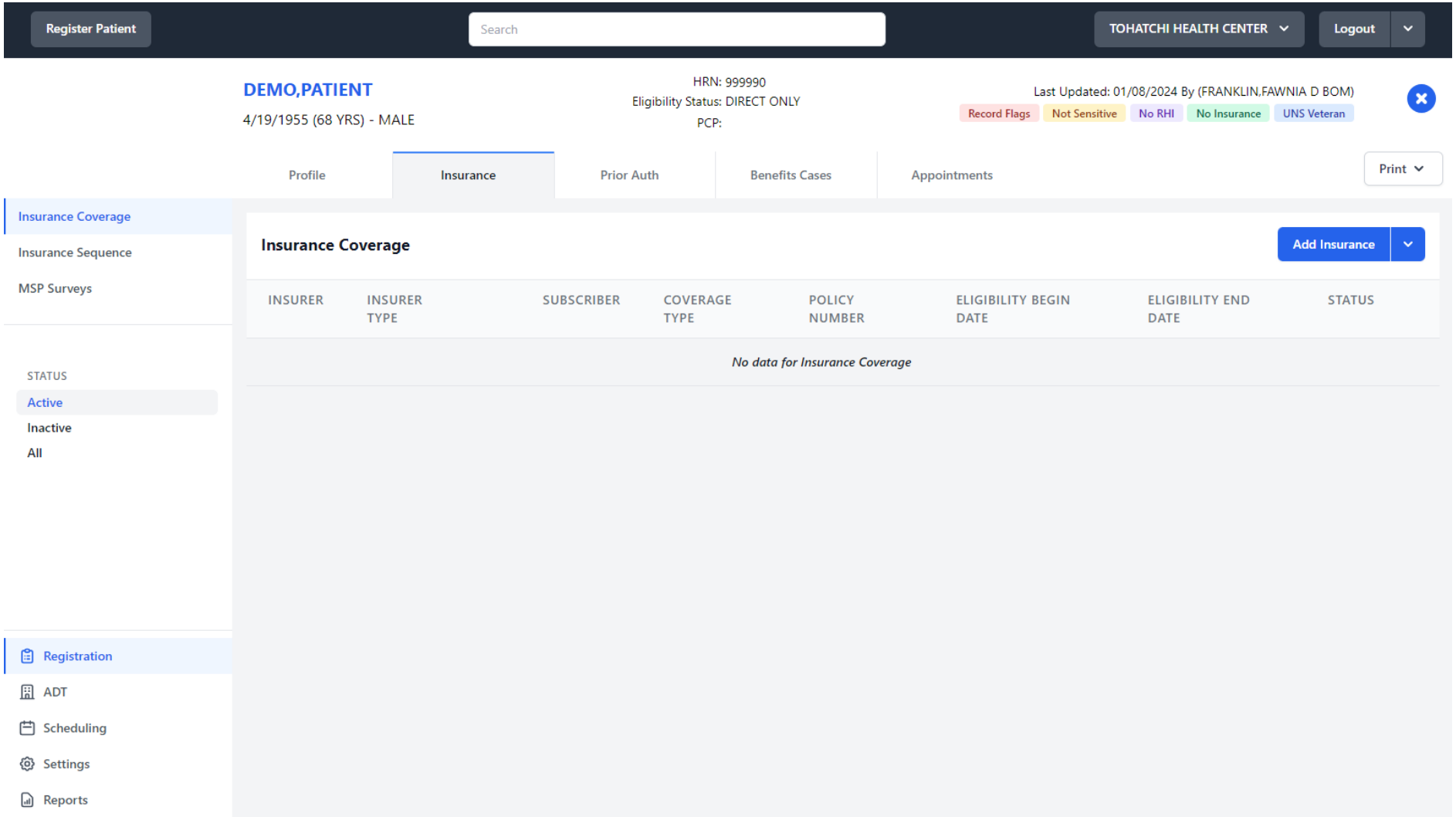
RX NCPDP/NAPB & RX NPI

DIAGNOSIS CODE

PROCEDURE CODE

RX NUMBER


Log Into Online Portal
or
Call Provider Number
Provider Information
Username and Password
Tax ID and/or NPI
Medicaid/Medicare ID
Contact Information
Patient Information
Member ID
Member Name
Member DOB
Receive Response
Effective/End Date
Member ID
Member Name
Member DOB
Group Number
Claims Address
Filing Limit
Covered Benefits
Add Insurance
or
Verify Coverage is Active


Register Patient
Search
TOHATCHI HEALTH CENTER
Logout
DEMO,PATIENT
4/19/1955 (68 YRS) - MALE
HRN: 999990
Eligibility Status: DIRECT ONLY
PCP:
Last Updated: 01/08/2024 By (FRANKLIN,FAWNIA D BOM)
Record Flags
Not Sensitive
No RHI
No Insurance
UNS Veteran
Profile
Insurance
Prior Auth
Benefits Cases
Appointments
Print
Insurance Coverage
Insurance Sequence
MSP Surveys
STATUS
Active
Inactive
All
Insurance Coverage
Add Insurance
INSURER
INSURER TYPE
SUBSCRIBER
COVERAGE TYPE
POLICY NUMBER
ELIGIBILITY BEGIN DATE
ELIGIBILITY END DATE
STATUS
No data for Insurance Coverage
Registration
ADT
Scheduling
Settings
Reports

STATE MEDICAID

TRADITIONAL MEDICAID

MANAGED CARE MEDICAID (MCO)

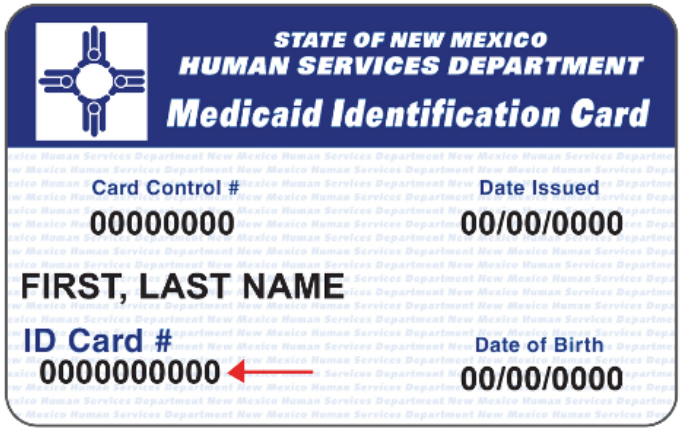
Medicaid.gov
Keeping America Healthy

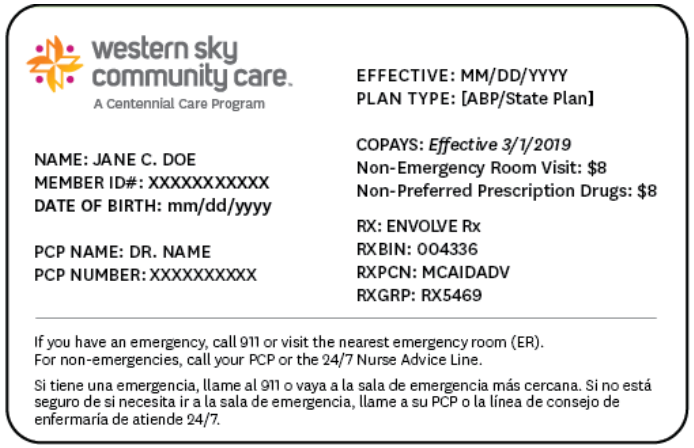
Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

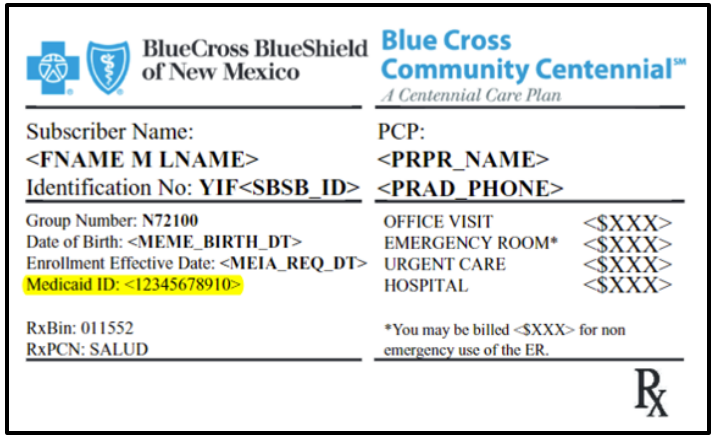
Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.

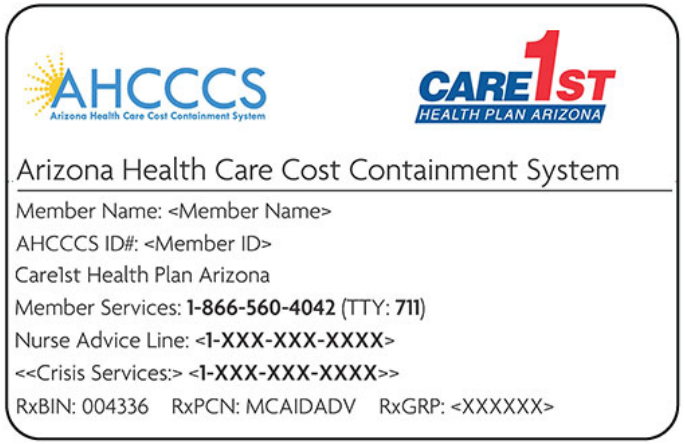
Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care.


STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
Medicaid Identification Card
Card Control #
00000000
Date Issued
00/00/0000
FIRST, LAST NAME
ID Card #
0000000000
Date of Birth
00/00/0000


western sky community care.
A Centennial Care Program
EFFECTIVE: MM/DD/YYYY
PLAN TYPE: [ABP/State Plan]
NAME: JANE C. DOE
MEMBER ID#: XXXXXXXXXX
DATE OF BIRTH: mm/dd/yyyy
COPAYS: Effective 3/1/2019
Non-Emergency Room Visit: $8
Non-Preferred Prescription Drugs: $8
PCP NAME: DR. NAME
PCP NUMBER: XXXXXXXXX
RX: ENVOLVE Rx
RXBIN: 004336
RXPCN: MCAIDADV
RXGRP: RX5469
If you have an emergency, call 911 or visit the nearest emergency room (ER).
For non-emergencies, call your PCP or the 24/7 Nurse Advice Line.
Si tiene una emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Si no está seguro de si necesita ir a la sala de emergencia, llame a su PCP o la línea de consejo de enfermería de atiende 24/7.

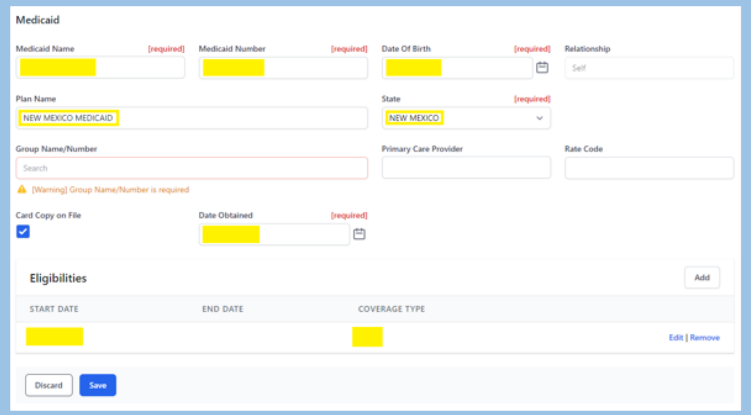

BlueCross BlueShield of New Mexico
Blue Cross Community Centennial℠
A Centennial Care Plan
Subscriber Name:
<FNAME M LNAME>
Identification No: YIF<SBSB_ID>
PCP:
<PRPR_NAME>
<PRAD_PHONE>
Group Number: N72100
Date of Birth: <MEME_BIRTH_DT>
Enrollment Effective Date: <MEIA_REQ_DT>
Medicaid ID: <12345678910>
OFFICE VISIT <$XXX>
EMERGENCY ROOM* <$XXX>
URGENT CARE <$XXX>
HOSPITAL <$XXX>
RxBin: 011552
RxPCN: SALUD
*You may be billed <$XXX> for non emergency use of the ER.
Rx

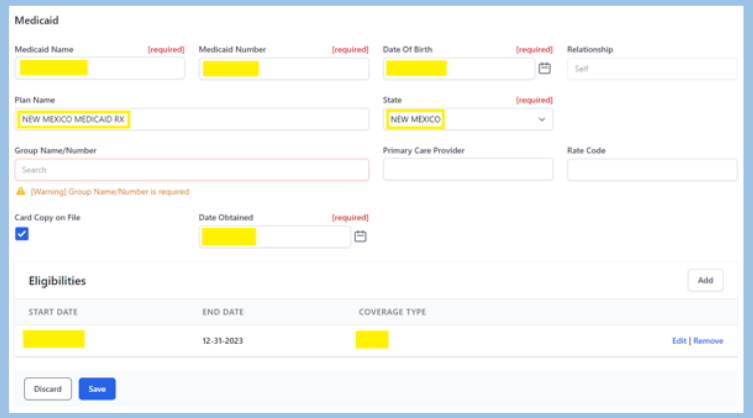

AHCCCS
Arizona Health Care Cost Containment System
arizona complete health.
Complete Care Plan
Arizona Health Care Cost Containment System
Member Name: <Paul S, Patient>
AHCCCS ID#: <A12345678> <CRS>
Primary Care Physician: <Paul M, Doctor>
Arizona Complete Health-Complete Care Plan
Member Services: 1-888-788-4408 - TTY/TDY: 711
Nurse Advice Line: 1-866-534-5963


AHCCCS
Arizona Health Care Cost Containment System
CARE1ST
HEALTH PLAN ARIZONA
Arizona Health Care Cost Containment System
Member Name: <Member Name>
AHCCCS ID#: <Member ID>
Care1st Health Plan Arizona
Member Services: 1-866-560-4042 (TTY: 711)
Nurse Advice Line: <1-XXX-XXX-XXXX>
<<Crisis Services:> <1-XXX-XXX-XXXX>>
RxBIN: 004336 RxPCN: MCAIDADV RxGRP: <XXXXXX>

NEW MEXICO MEDICAID (TRADITIONAL)

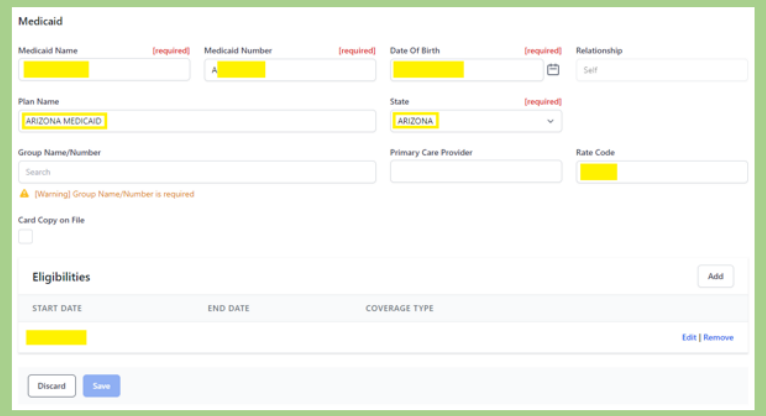
NM MEDICAID ID	TAX ID	NPI	RX NPI	RX NCPDP
800-820-6901 / 888-997-2583				
https://nmmedicaid.portal.conduent.com/static/providerlogin.htm				

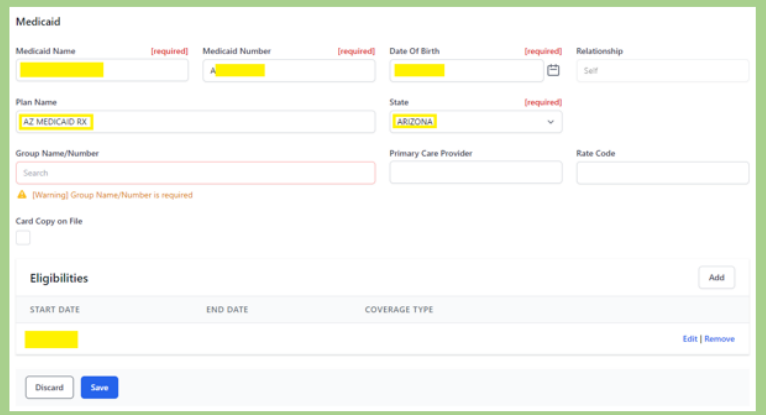




ARIZONA MEDICAID

AZ MEDICAID ID	TAX ID	NPI	RX NPI	RX NCPDP
602-417-7670				
https://ao.azahcccs.gov/Account/Login.aspx?ReturnUrl=%2f				





Medicaid

Medicaid Name [required]

Medicaid Number [required]

Date Of Birth [required]

Relationship

Self

Plan Name

NEW MEXICO MEDICAID

State [required]

NEW MEXICO

Group Name/Number

Search

[Warning] Group Name/Number is required

Primary Care Provider

Rate Code

Card Copy on File

Date Obtained [required]

02-01-2024

Eligibilities

Add

START DATE	END DATE	COVERAGE TYPE	
01-01-2023	12-31-2023	100	Edit | Remove
01-01-2024		04	Edit | Remove

Discard Save

Eligibility Inquiry

To inquire on a Date of Service range, enter a 'From' date and a 'To' date.

To inquire on a single Date of Service, enter only a 'From' date.

Then enter the Recipient Inquiry criteria and click 'Submit'.

* denotes required fields

* Date of Service (From):	mm/dd/ccyy
Date of Service (To):	mm/dd/ccyy

***Recipient Inquiry**

○	Recipient ID:					
○	Card ID:		Located on front of recipient's Medicaid card.			
○	SSN:		Date of Birth:	mm/dd/ccyy		
○	Last Name:		First Name:		Date of Birth:	mm/dd/ccyy

Submit Clear

Eligibility Response

02/27/2024 11:56 AM MST

Inquiry Criteria			
Date of Service :	01/01/2010 To: 02/27/2024	Provider ID:	000001
SSN:	123456789	Date of Birth:	04/18/1955

For the requested date(s) of service, your inquiry returned the following eligibility information.

Please note that end dates greater than today's date, such as 12/31/9999, do not indicate eligibility beyond the date and time of this inquiry.

Recipient Information			
Recipient ID:	0000987654321	Recipient Name:	DEMO,PATIENT MNAME
Date of Birth:	04/18/1955	Sex:	Male
Medicaid Card ID:	987654321	Recertification Date:	12/31/2024
Date of Death:		Race:	American Indian
Residential Address:	000 COUGAR TRAIL TOHATCHI, NM 87325		
Mailing Address:	PO BOX 000 TOHATCHI, NM 87325		

Category of Eligibility Information

COE Code	Benefit Description	Begin Date	End Date	COE Add Date	Co-Pay
100	Alternative Benefit Package limitations on some services	10/01/2023	12/31/9999	12/13/2023	

Lock-In Information

Lock In Type	Provider Name	Begin Date	End Date
BEHAVIORAL HLTH STATEWIDE ENT.	OPTUMHEALTH, CSC	07/01/2009	12/31/2013
PREFERRED DRUG LIST - NMRX	PRESBYTERIAN PREFERRED DRUG	08/01/2005	07/31/2010

Third Party Liability Information

No TPL information on file for the requested date of service

Modify Criteria | New Inquiry

Medicaid

Medicaid Name [required]: DEMO,PATIENT

Medicaid Number [required]:

Date Of Birth [required]: 04-19-1955

Relationship: Self

Plan Name: NEW MEXICO MEDICAID

State [required]: NEW MEXICO

Group Name/Number: Search

[Warning] Group Name/Number is required

Primary Care Provider:

Rate Code:

Card Copy on File: ☑

Date Obtained [required]: 02-01-2024

Eligibilities

Add

START DATE	END DATE	COVERAGE TYPE	
10-01-2023		100	Edit | Remove

Discard | Save

Medicaid

Medicaid Name [required]: DEMO,PATIENT MNAME

Medicaid Number [required]: 987654321

Date Of Birth [required]: 04-18-1955

Relationship: Self

Plan Name: NEW MEXICO MEDICAID

State [required]: NEW MEXICO

Group Name/Number: Search

[Warning] Group Name/Number is required

Primary Care Provider:

Rate Code:

Card Copy on File: ☑

Date Obtained [required]: 02-01-2024

Eligibilities

Add

START DATE	END DATE	COVERAGE TYPE	
10-01-2023		100	Edit | Remove

Discard Save

MEDICARE

TRADITIONAL MEDICARE & RAILROAD RETIREMENT

MEDIGAP

MEDICARE ADVANTAGE PLANS AKA MEDICARE PART C

MEDICARE PART D

MEDICARE

Medicare.gov

The federal health insurance program for:

- People who are 65 or older
- Certain younger people with disabilities
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD)

The **different parts of Medicare** help cover specific services:

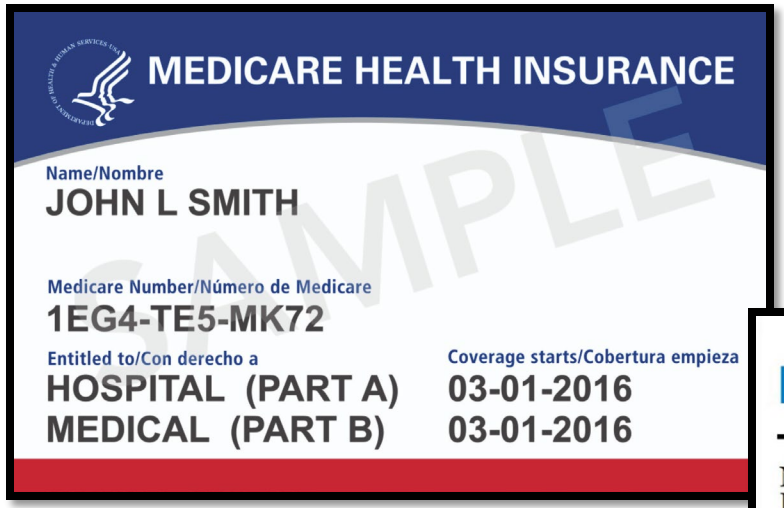
- **Medicare Part A (Hospital Insurance)**
  Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.
- **Medicare Part B (Medical Insurance)**
  Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.
- **Medicare Part D (prescription drug coverage)**
  Helps cover the cost of prescription drugs (including many recommended shots or vaccines).

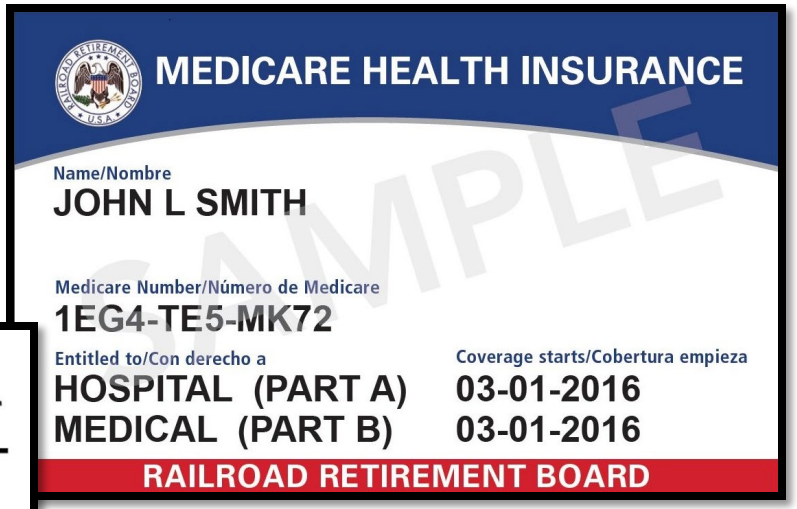
Original Medicare pays for much, but not all, of the cost for covered health care services and supplies.

Medigap is a Medicare Supplement Insurance policy that can help pay some of the remaining health care costs, like copayments, coinsurance, and deductibles. Some Medigap policies also cover services that Original Medicare doesn't cover, like emergency medical care when you travel outside the U.S.

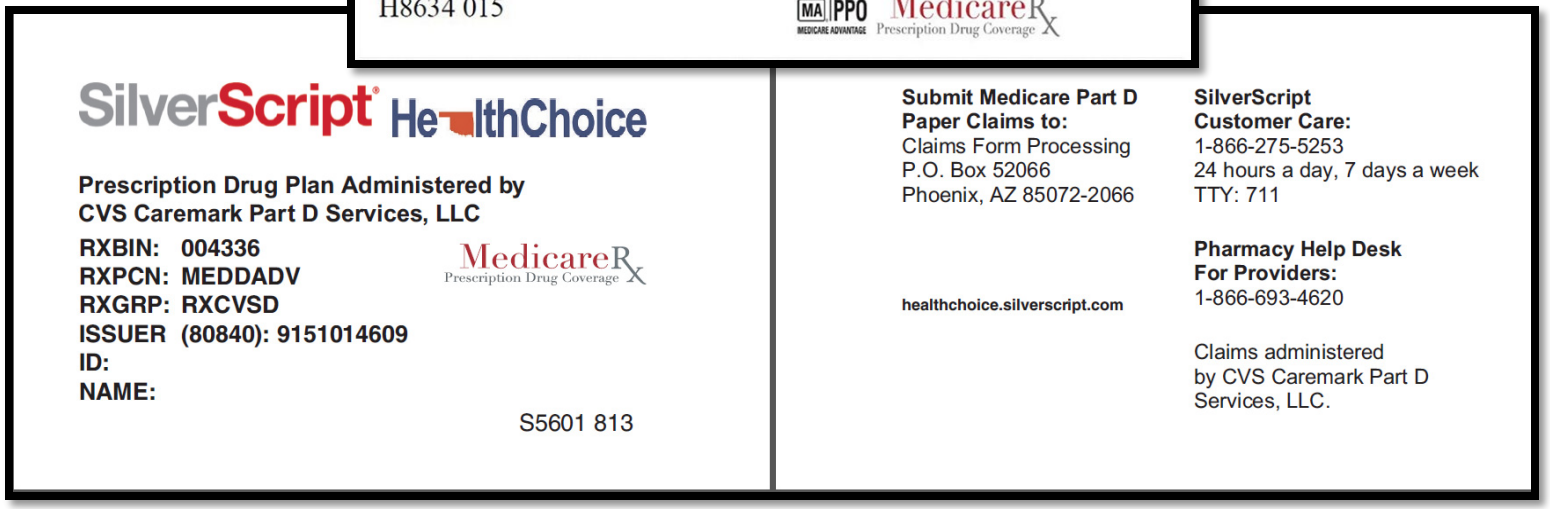
Medicare Advantage is Medicare-approved plan from a private company that offers an alternative to Original Medicare for health and drug coverage. These “bundled” plans include Part A, Part B, and usually Part D. Plans may offer some extra benefits that Original Medicare doesn’t cover — like vision, hearing, and dental services.

Medicare drug coverage helps pay for prescription drugs.


MEDICARE HEALTH INSURANCE
Name/Nombre
JOHN L SMITH
Medicare Number/Número de Medicare
1EG4-TE5-MK72
Entitled to/Con derecho a
Coverage starts/Cobertura empieza
HOSPITAL (PART A) 03-01-2016
MEDICAL (PART B) 03-01-2016
SAMPLE


MEDICARE HEALTH INSURANCE
Name/Nombre
JOHN L SMITH
Medicare Number/Número de Medicare
1EG4-TE5-MK72
Entitled to/Con derecho a
Coverage starts/Cobertura empieza
HOSPITAL (PART A) 03-01-2016
MEDICAL (PART B) 03-01-2016
RAILROAD RETIREMENT BOARD
SAMPLE


BlueCross BlueShield of New Mexico
Blue Cross Medicare Advantage (PPO)
Name: SampleCard
ID: YID123456789
Plan (80840): 9101000237
OfficeVisit: $
Specialist: $
Emergency Room: $
RxBin: RXBIN
RxPCN: RXPCN
RxGrp: RXGROUP
RxID: RXID
Plan: Blue Cross Medicare Advantage Flex (PPO)
H8634 015
MA PPO MEDICARE ADVANTAGE
MedicareRx Prescription Drug Coverage


SilverScript HealthChoice
Prescription Drug Plan Administered by
CVS Caremark Part D Services, LLC
RXBIN: 004336
RXPCN: MEDDADV
RXGRP: RXCVSD
ISSUER (80840): 9151014609
ID:
NAME:
MedicareRx Prescription Drug Coverage
S5601 813
Submit Medicare Part D Paper Claims to:
Claims Form Processing
P.O. Box 52066
Phoenix, AZ 85072-2066
healthchoice.silverscript.com
SilverScript Customer Care:
1-866-275-5253
24 hours a day, 7 days a week
TTY: 711
Pharmacy Help Desk For Providers:
1-866-693-4620
Claims administered by CVS Caremark Part D Services, LLC.

Medicare

Medicare Name [required]

Medicare MBI Number [required]

Date Of Birth [required]

Medicare Release Date [required]

01-01-2024

Medicare HICN Number

Suffix

Please Select

Primary Care Provider

QMB/SLMB

Please Select

Advance Beneficiary Notice Obtained

__-__-____

IMP MSG FORM SIGN Obtained Date

__-__-____

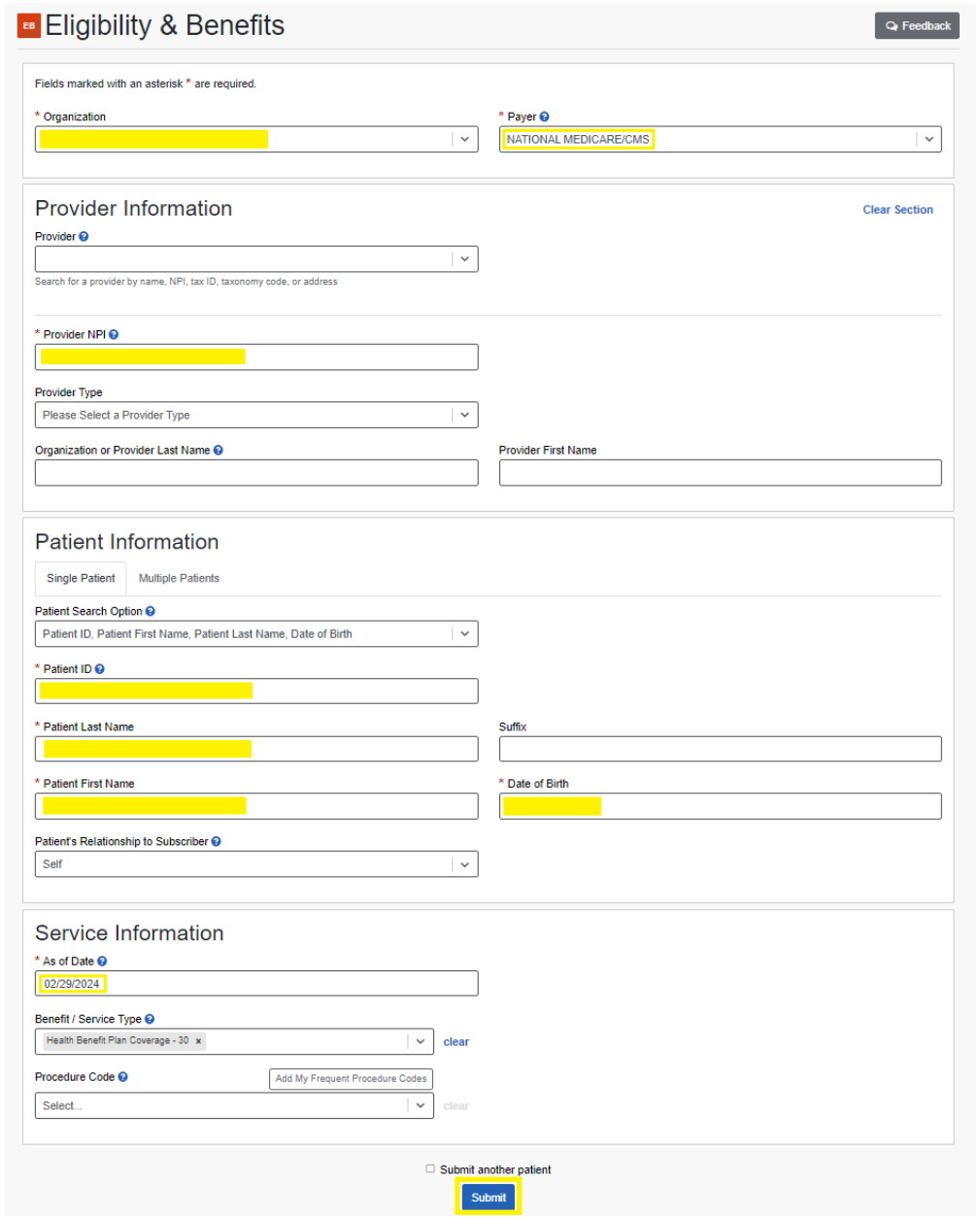
Card Copy on File

Eligibilities

Add

START DATE	END DATE	COVERAGE TYPE	
01-01-2024		A	Edit | Remove
01-01-2024		B	Edit | Remove

Discard Save


Eligibility & Benefits
Feedback
Fields marked with an asterisk * are required.
* Organization
* Payer
NATIONAL MEDICARE/CMS
Provider Information
Clear Section
Provider
Search for a provider by name, NPI, tax ID, taxonomy code, or address
* Provider NPI
Provider Type
Please Select a Provider Type
Organization or Provider Last Name
Provider First Name
Patient Information
Single Patient
Multiple Patients
Patient Search Option
Patient ID, Patient First Name, Patient Last Name, Date of Birth
* Patient ID
* Patient Last Name
Suffix
* Patient First Name
* Date of Birth
Patient's Relationship to Subscriber
Self
Service Information
* As of Date
02/29/2024
Benefit / Service Type
Health Benefit Plan Coverage - 30
clear
Procedure Code
Add My Frequent Procedure Codes
Select...
clear
Submit another patient
Submit

DEMO,PATIENT
PO BOX 000
TOHATCHI, NM 87325

Edit | Print | Feedback

Member Status	Date of Birth	Gender	Relationship to Subscriber
Active Coverage	Apr 18, 1955	Male	Self

Member ID: 1EG4TE5MK72
Eligibility Begin Date: Feb 27, 2024

Payer: CMS

Other or Additional Payer Information
No additional payer information provided.

▾ Provider Information

Requesting Provider
Name:
Category: Requesting Provider
NPI:

Plan Maximums and Deductibles

▾ Health Benefit Plan Coverage - 30

Active Coverage
Coverage Start Date: Aug 1, 2012
Insurance Type: Medicare Part A
- 0-Beneficiary insured due to age OASI

Inactive
Insurance Type: Medicare Part B

	Information / Details	
Annual Deductible	**Coverage Start Date:** Jan 1, 2024 **Coverage End Date:** Dec 31, 2024 **Insurance Type:** Medicare Part A	$1,632 / Episode(s) -$0 Year to Date

Medicare

Medicare Name [required]	Medicare MBI Number [required]	Date Of Birth [required]	Medicare Release Date [required]
DEMO,PATIENT,SR		04-19-1955	08-01-2012

Medicare HICN Number	Suffix	Primary Care Provider	QMB/SLMB
987654321	A		Please Select

Advance Beneficiary Notice Obtained	IMP MSG FORM SIGN Obtained Date	Card Copy on File
__-__-____	__-__-____	☐

Eligibilities

Add

START DATE	END DATE	COVERAGE TYPE	
08-01-2012		A	Edit | Remove

Discard | Save

Medicare

Medicare Name [required]: DEMO,PATIENT

Medicare MBI Number [required]: 1EG4TE5MK72

Date Of Birth [required]: 04-18-1955

Medicare Release Date [required]: 08-01-2012

Medicare HICN Number: 987654321

Suffix: A

Primary Care Provider:

QMB/SLMB: Please Select

Advance Beneficiary Notice Obtained: __-__-____

IMP MSG FORM SIGN Obtained Date: __-__-____

Card Copy on File

Eligibilities

Add

START DATE	END DATE	COVERAGE TYPE	
08-01-2012	08-02-2012	A	Edit | Remove

Discard | Save

MEDICARE SECONDARY PAYER QUESTIONNAIRE

The Medicare Secondary Payer Questionnaire contains questions that can be used to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers may use this as a guide to help identify other payers that may be primary to Medicare.

Medicare Secondary Payer Questionnaire

PATIENT INFORMATION

Patient's Name: _____ **Patient's Age:** _____ **Patient's Sex:** _____ **HRN #:** _____

PART I:

1. Are you receiving Black Lung (BL) Benefits?
   _____ Yes. Date benefits began ____/____/____
   BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.
   _____ No.
2. Are the services to be paid by a government program such as a research grant?
   _____ Yes. Government program will pay primarily benefits for these services.
   _____ No.
3. Has the Department of Veteran Affairs (DVA) authorized and agreed to pay for care at this facility?
   _____ Yes. **DVA IS PRIMARY FOR THESE SERVICES.**
   _____ No.
4. Was the illness/injury due to a work-related accident/condition?
   _____ Yes. Date of injury/illness: ____/____/____
   _____ No.
   Name and Address of Worker's Compensation (WC) plan:
   _____
   _____
   _____
   Patient's Policy or Identification Number: _____
   Name and Address of Employer:
   _____
   _____
   _____

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILNESS. GO TO PART III.

_____ No. **GO TO PART II.**

PART II.

1. Was illness/injury due to a non-work related accident?
   _____ Yes. Date of accident: ____/____/____
   _____ No. **GO TO PART III.**
2. What type of accident caused the illness/injury?
   _____ Automobile
   _____ Non-Automobile
   Name and Address of no-fault or liability insurer:
   _____
   _____
   _____

NO-FAULT INSURER IS PRIMARY PAYOR ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

_____ Other.

3. Was another party responsible for this accident?
   _____ Yes.

Name and Address of any liability insurer:
_____
_____
_____
Insurance claim number:_____

LIABILITY INSURER IS PRIMARY ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

_____No. **GO TO PART III.**

PART III.

1. Are you entitled to Medicare based on:

   _____ Age….**GO TO PART IV.**
   _____ Disability….**GO TO PART V.**
   _____ ESRD (End Stage Renal Disease)….**GO TO PART VI.**

PART IV – AGE

1. Are you currently employed?
   _____ Yes.
   Name and Address of your employer:
   _____
   _____
   _____
   _____ No. Date of Retirement: ____/____/____
2. Is your spouse currently employed?
   _____ Yes.
   Name and Address of spouse's employer:
   _____
   _____
   _____
   _____ No. Date of Retirement: ____/____/____

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR PART II. DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment?
   _____ Yes
   _____ No. **STOP! MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**
4. Does the employer that sponsors your GHP employ 20 or more employees?
   _____ Yes. **STOP! GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**
   Name and Address of GHP:
   _____
   _____
   _____
   Policy Identification Number:_____
   Group Identification Number:_____
   Name of Policy Holder:_____
   Relationship to patient:_____

_____ No. **STOP! MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

PART V – DISABILITY

1. Are you currently employed?
   _____ Yes.
   Name and Address of employer:
   _____
   _____
   _____
   _____ No.
2. Is a family member currently employed?
   _____ Yes.
   Name and Address of employer:
   _____
   _____
   _____
   _____ No.

IF THE PATIENT ANSWERS NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR PART II. DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?
   _____ Yes.
   _____ No. **STOP! MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**
4. Does the employer that sponsors your GHP, employ 100 or more employees?
   _____ Yes. **STOP! GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**
   Name and Address of GHP:
   _____
   _____
   _____
   Policy Identification number: _____
   Group Identification number: _____
   Name of Policy Holder: _____
   Relationship to patients: _____
   _____ No. **STOP! MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

PART VI – ESRD (End Stage Renal Disease)

1. Do you have group health plan (GHP) coverage?
   _____ Yes.
   Name and Address of GHP:
   _____
   _____
   _____
   Policy Identification number: _____
   Group Identification number: _____
   Name of Policy Holder: _____
   Relationship to patient: _____
   Name and Address of employer, if any, from which you receive GHP coverage:
   _____
   _____
   _____

_____ No. **STOP! MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?
   _____ Yes. Date of transplant: ____/____/____
   _____ No.
3. Have you received maintenance dialysis treatments?
   _____ Yes. Date dialysis began: ____/____/____
   If you participated in a self dialysis-training program, provide date training started: ____/____/____
   _____ No.
4. Are you within the 30-month coordination period?
   _____ Yes.
   _____ No. **STOP! MEDICARE IS PRIMARY.**
5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?
   _____ Yes.
   _____ No. **STOP! GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**
6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?
   _____ Yes. **STOP! GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
   _____ No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**
7. Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement?)
   _____ Yes. **GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
   _____ No. **MEDICARE CONTINUES TO PAY PRIMARY.**

Failure to obtain the information listed in these sections is a violation of your provider agreement with Medicare. (SEE Section 142.3F.) The information you must obtain is essential to filing a proper claim with Medicare or a primary payer. Failure to file a proper claim can result in the unnecessary denial or development of claims.

Name/Signature (thumbprint) of Beneficiary: _____

Signature of representative _____Relationship (person giving information)_____

Beneficiary's Medicare Number: _____ Date Form Completed: _____ Clerk: _____

OUTPATIENT / EMERGENCY ROOM / ADMISSION (circle one) VISIT DATE: _____

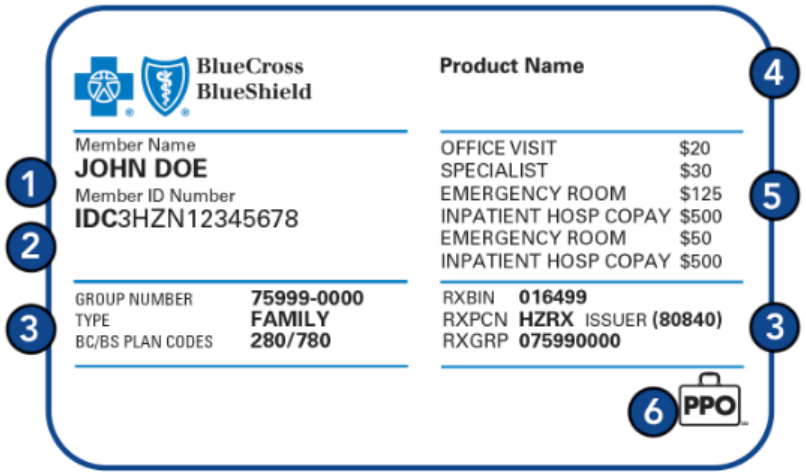
Comments _____
_____
_____

Address-o-graph:

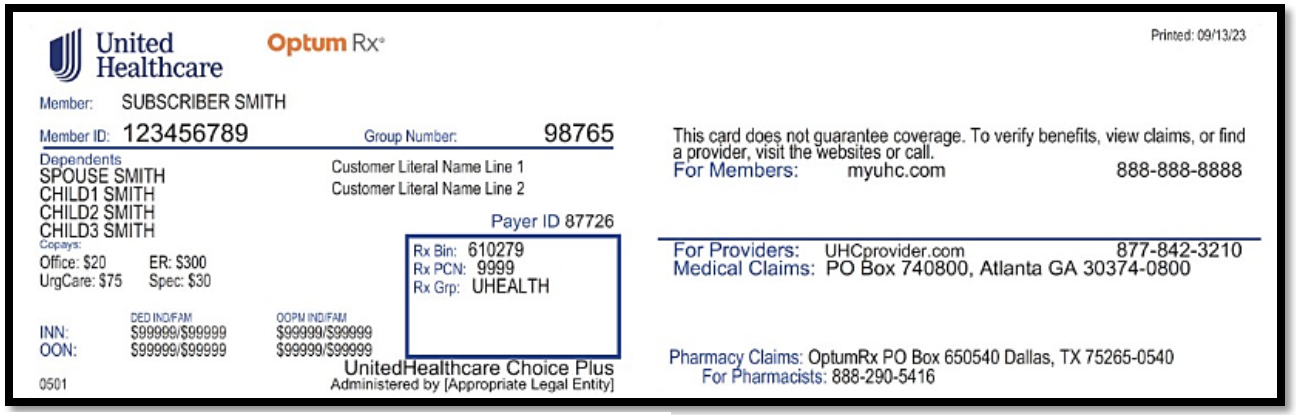
PRIVATE INSURANCE

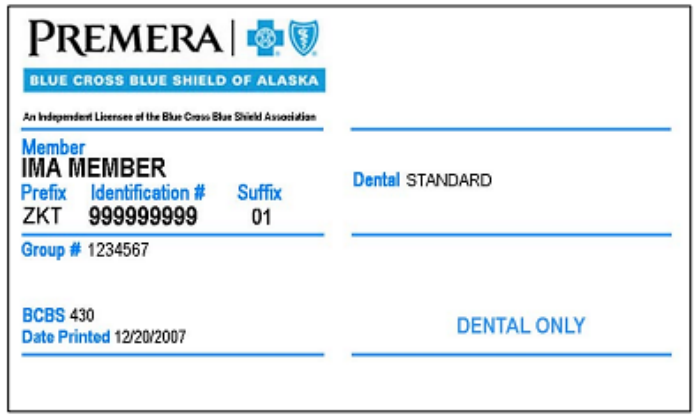
EMPLOYER HEALTH INSURANCE

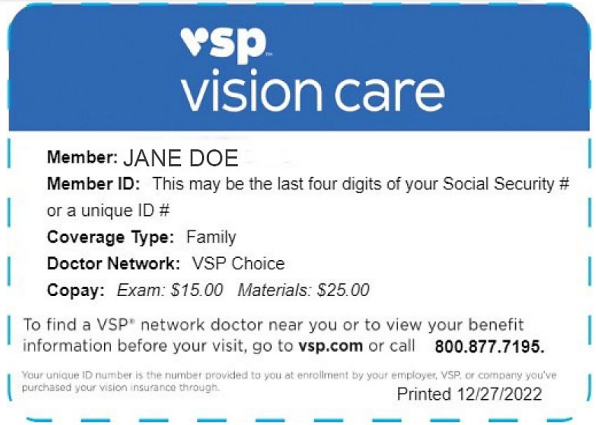
MARKETPLACE HEALTH INSURANCE

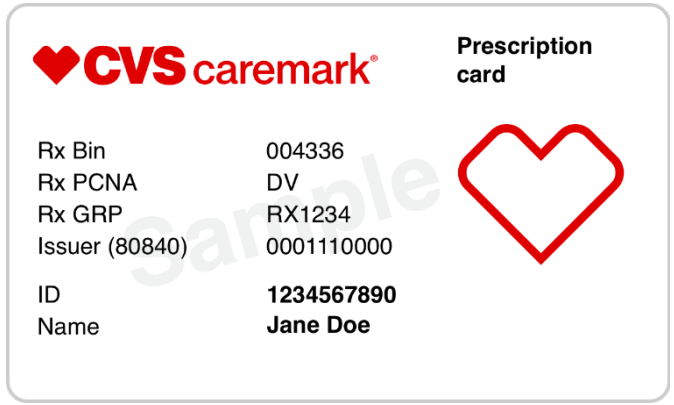

BlueCross BlueShield
Product Name
1
Member Name
JOHN DOE
2
Member ID Number
IDC3HZN12345678
3
GROUP NUMBER 75999-0000
TYPE FAMILY
BC/BS PLAN CODES 280/780
4
OFFICE VISIT $20
SPECIALIST $30
5
EMERGENCY ROOM $125
INPATIENT HOSP COPAY $500
EMERGENCY ROOM $50
INPATIENT HOSP COPAY $500
RXBIN 016499
RXPCN HZRX ISSUER (80840)
RXGRP 075990000
3
6
PPO


9
Horizon
7
Hospitals or Providers: File Claims with local Blue Cross and/or Blue Shield Plan.
Members: See your Benefit Booklet for covered services. Possession of this card does not guarantee eligibility for benefits.
Horizon Blue Cross Blue Shield of New Jersey is an independent licensee of the Blue Cross and Blue Shield Association. Insured by Horizon BCBSNJ
11
A network administrator outside of the Horizon service area.
8
PRIME THERAPEUTICS
www.horizonblue.com/nationalaccounts
For Member Use Only
Member Services 1-800-355-2583
Behavioral Health Services 1-800-626-2212
Provider Locator 1-800-810-2583
24/7 Nurse Line 1-888-624-3096
Dental Customer Line 1-888-624-6825
10
For Provider Use
Utilization Management 1-800-664-2283
Provider Services 1-800-624-1110
Pharmacists 1-877-686-6875
MEMBER CLAIM FILING:
HORIZON BCBSNJ
PO BOX 1219
NEWARK, N.J. 07105-1219
*Medicare members submit claims to Medicare first.
7
AN INDEPENDENT COMPANY ADMINISTERING PHARMACY BENEFITS.


United Healthcare
Optum Rx
Printed: 09/13/23
Member: SUBSCRIBER SMITH
Member ID: 123456789
Group Number: 98765
Dependents
SPOUSE SMITH
CHILD1 SMITH
CHILD2 SMITH
CHILD3 SMITH
Copays:
Office: $20 ER: $300
UrgCare: $75 Spec: $30
Customer Literal Name Line 1
Customer Literal Name Line 2
Payer ID 87726
Rx Bin: 610279
Rx PCN: 9999
Rx Grp: UHEALTH
DED IND/FAM
OOPM IND/FAM
INN: $99999/$99999 $99999/$99999
OON: $99999/$99999 $99999/$99999
0501
UnitedHealthcare Choice Plus
Administered by [Appropriate Legal Entity]
This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the websites or call.
For Members: myuhc.com 888-888-8888
For Providers: UHCprovider.com 877-842-3210
Medical Claims: PO Box 740800, Atlanta GA 30374-0800
Pharmacy Claims: OptumRx PO Box 650540 Dallas, TX 75265-0540
For Pharmacists: 888-290-5416


PREMERA
BLUE CROSS BLUE SHIELD OF ALASKA
An Independent Licensee of the Blue Cross Blue Shield Association
Member
IMA MEMBER
Prefix Identification # Suffix
ZKT 999999999 01
Group # 1234567
BCBS 430
Date Printed 12/20/2007
Dental STANDARD
DENTAL ONLY


vsp
vision care
Member: JANE DOE
Member ID: This may be the last four digits of your Social Security # or a unique ID #
Coverage Type: Family
Doctor Network: VSP Choice
Copay: Exam: $15.00 Materials: $25.00
To find a VSP® network doctor near you or to view your benefit information before your visit, go to vsp.com or call 800.877.7195.
Your unique ID number is the number provided to you at enrollment by your employer, VSP, or company you've purchased your vision insurance through.
Printed 12/27/2022


CVS caremark
Prescription card
Rx Bin 004336
Rx PCNA DV
Rx GRP RX1234
Issuer (80840) 0001110000
ID 1234567890
Name Jane Doe
Sample

THIRD PARTY VERIFICATION SHEET

TAX ID NPI RX NPI RX NCPDP/NABP

PATIENT INFORMATION

NAME		HRN	**MALE FEMALE**
MAILING ADDRESS		SSN	DOB
CITY	STATE	ZIP	PHONE NUMBER

POLICY HOLDER'S INFORMATION

NAME		HRN	**MALE FEMALE**
MAILING ADDRESS (IF DIFFERENT FROM PATIENT'S ADDRESS)		SSN	DOB
CITY	STATE	ZIP	PHONE NUMBER
EMPLOYER'S NAME		EMPLOYMENT STATUS **FULL PART UNEMP UNK RETIRED**	RETIREMENT DATE
CITY	STATE	ZIP	PHONE NUMBER

COVERAGE INFORMATION

INSURER COVERS **MEDICAL MENTAL HEALTH DENTAL RX EYE**		COVERAGE TYPE **PPO POS HMO OTHER**	
POLICY NUMBER		COORDINATION OF BENEFITS – SEQUENCE AS: **PRIMARY SECONDARY TERTIARY OTHER**	
EFFECTIVE DATE		TERM DATE	
INSURER NAME		GROUP NAME	
CLAIMS ADDRESS (POB or STREET)		GROUP NUMBER	
CITY	STATE	ZIP	FILING LIMIT
VERIFICATION NUMBER	PRECERT NUMBER		PRECERT REQUIRED **INPT OUTPT PROCS OTHER**
ADDITIONAL INFO			**FOR RX** BIN _____ PCN _____

18 Self / 01 Spouse / 19 Child / 21 Unknown / 39 Organ Donor / 40 Cadaver Donor / 53 Life Partner / G8 Other Relationship

REP'S NAME	VERIFIED BY	DATE

PAGE 1 OF 2

TAX ID NPI RX NPI RX NCPDP/NABP

PAGE 2 OF 2

NAME	HRN

COVERAGE INFORMATION

MEDICAL MENTAL HEALTH DENTAL RX EYE		**PPO POS HMO OTHER**	
POLICY NUMBER		**PRIMARY SECONDARY TERTIARY OTHER**	
EFFECTIVE DATE		TERM DATE	
INSURER NAME		GROUP NAME	
CLAIMS ADDRESS (POB or STREET)		GROUP NUMBER	
CITY	STATE	ZIP	FILING LIMIT
VERIFICATION NUMBER	PRECERT NUMBER		**INPT OUTPT PROCS OTHER**
ADDITIONAL INFO			**FOR RX** BIN _____ PCN _____

REP'S NAME	VERIFIED BY	DATE

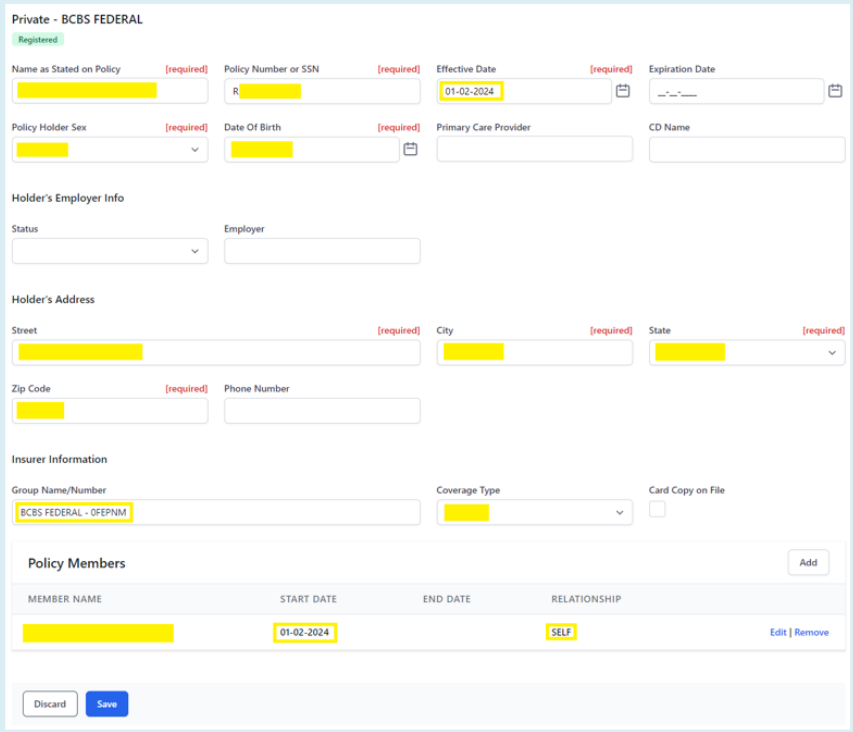
COVERAGE INFORMATION

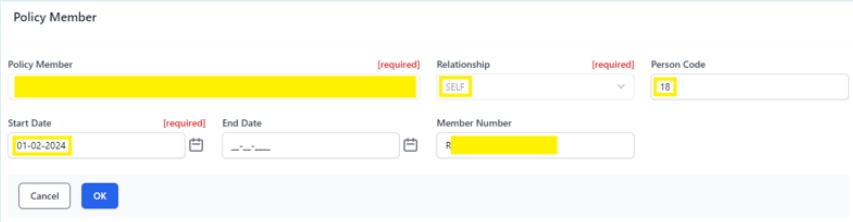
MEDICAL MENTAL HEALTH DENTAL RX EYE		**PPO POS HMO OTHER**	
POLICY NUMBER		**PRIMARY SECONDARY TERTIARY OTHER**	
EFFECTIVE DATE		TERM DATE	
INSURER NAME		GROUP NAME	
CLAIMS ADDRESS (POB or STREET)		GROUP NUMBER	
CITY	STATE	ZIP	FILING LIMIT
VERIFICATION NUMBER	PRECERT NUMBER		**INPT OUTPT PROCS OTHER**
ADDITIONAL INFO			**FOR RX** BIN _____ PCN _____

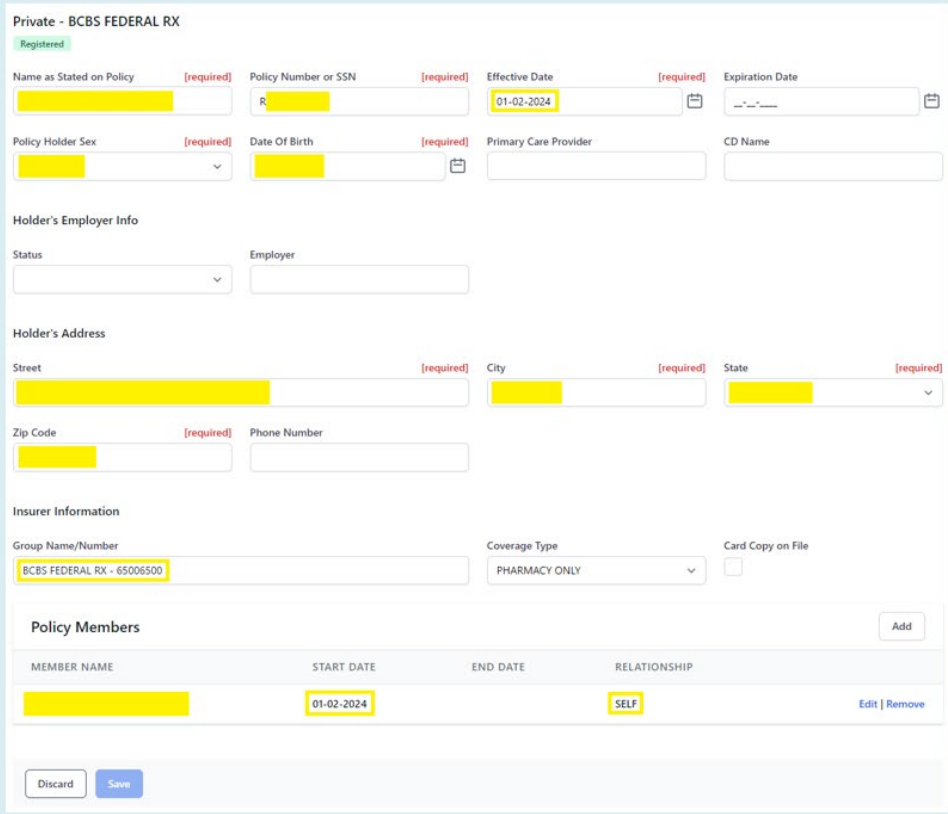
REP'S NAME	VERIFIED BY	DATE

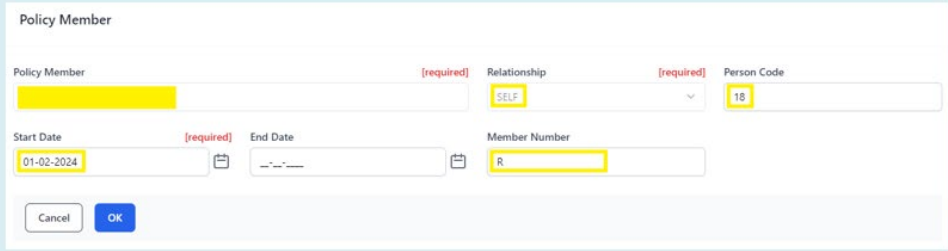
FEDERAL EMPLOYEE BCBS

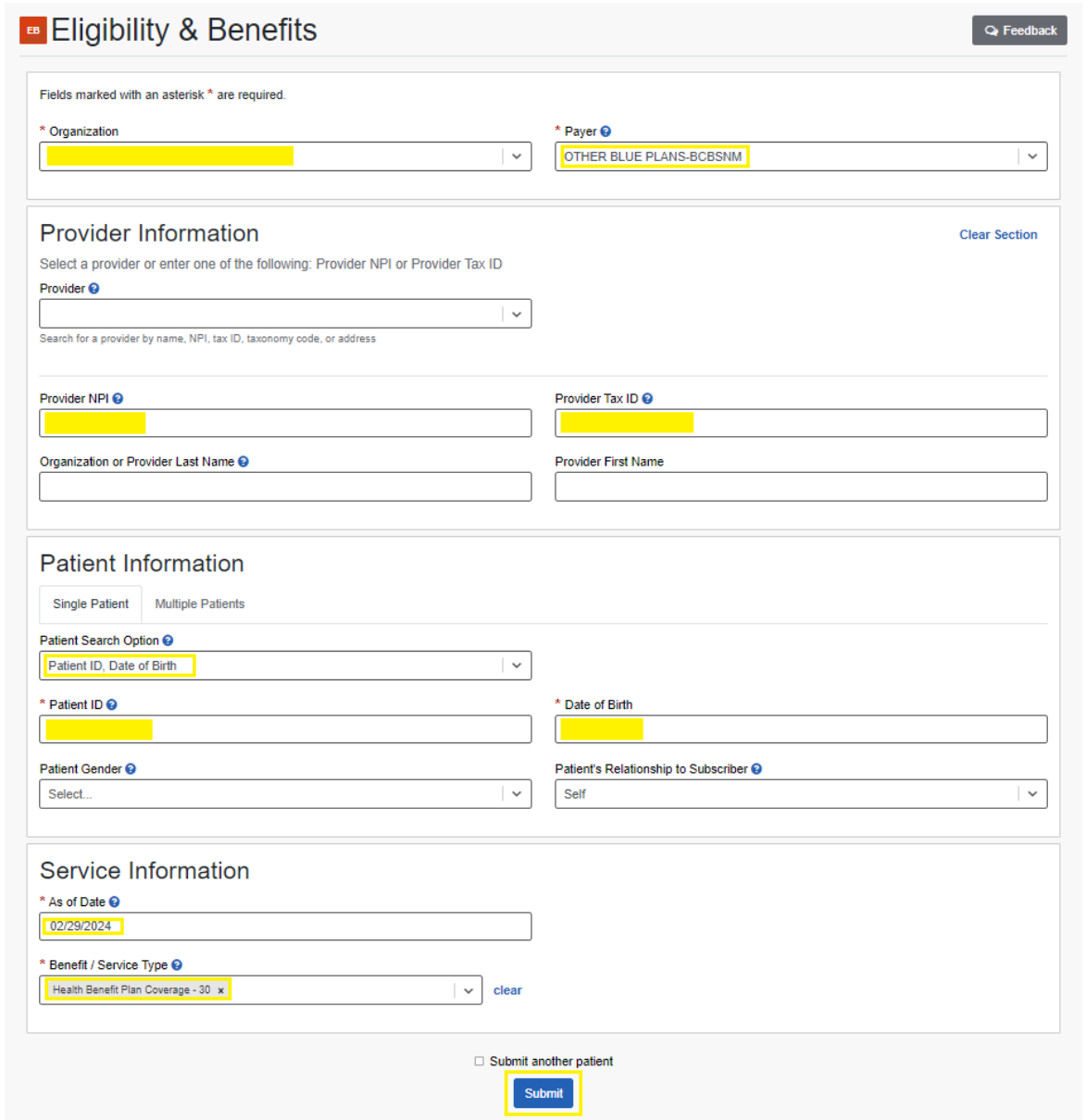
TAX ID	NPI	RX NPI	RX NCPDP
BCBS FEDERAL		800-245-1609	
AVAILITY			

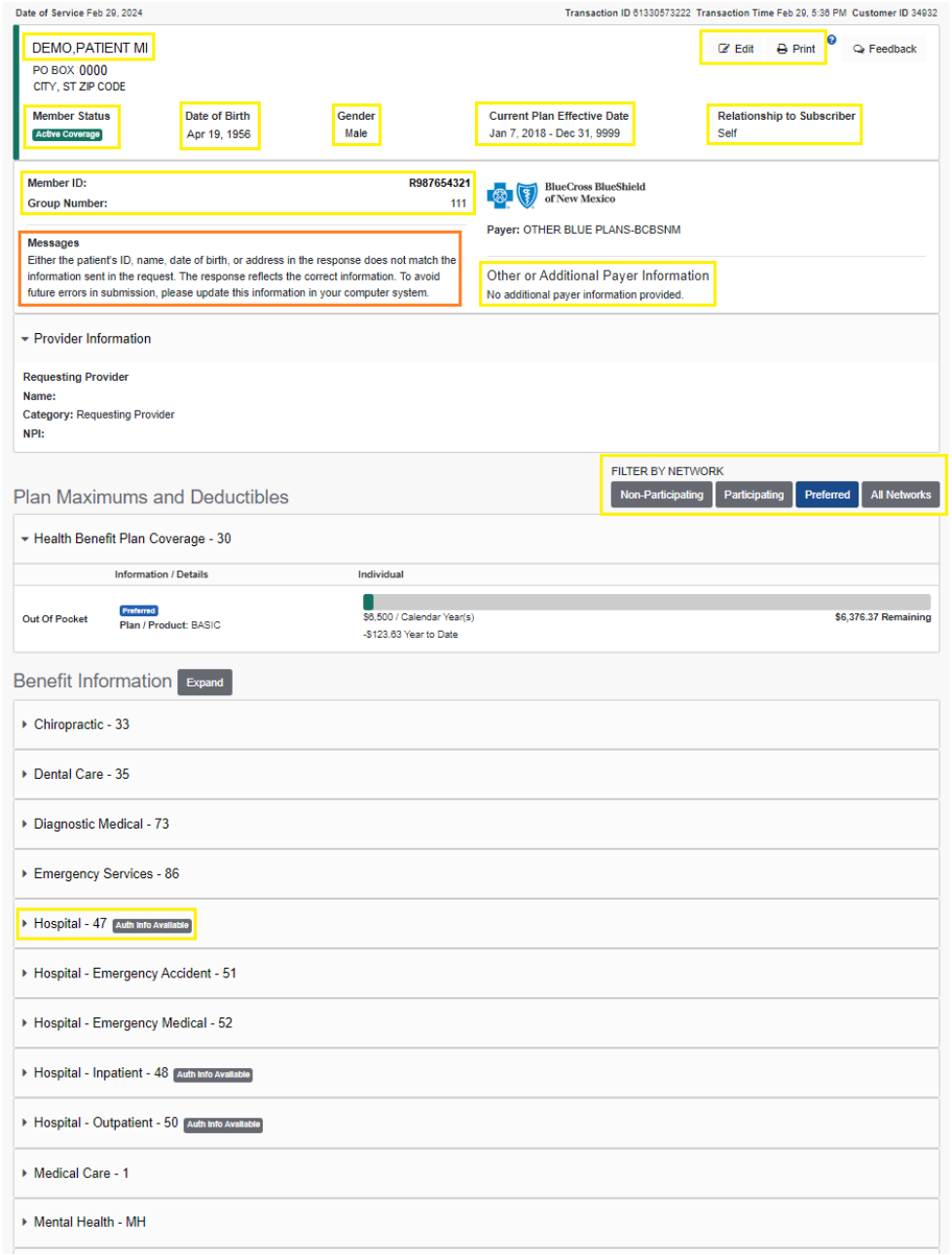









Eligibility & Benefits
Feedback
Fields marked with an asterisk * are required.
* Organization
* Payer
OTHER BLUE PLANS-BCBSNM
Provider Information
Clear Section
Select a provider or enter one of the following: Provider NPI or Provider Tax ID
Provider
Search for a provider by name, NPI, tax ID, taxonomy code, or address
Provider NPI
Provider Tax ID
Organization or Provider Last Name
Provider First Name
Patient Information
Single Patient
Multiple Patients
Patient Search Option
Patient ID, Date of Birth
* Patient ID
* Date of Birth
Patient Gender
Select...
Patient's Relationship to Subscriber
Self
Service Information
* As of Date
02/29/2024
* Benefit / Service Type
Health Benefit Plan Coverage - 30
clear
Submit another patient
Submit


Date of Service Feb 29, 2024
Transaction ID 61330573222 Transaction Time Feb 29, 5:36 PM Customer ID 34932
DEMO,PATIENT MI
PO BOX 0000
CITY, ST ZIP CODE
Edit
Print
Feedback
Member Status
Active Coverage
Date of Birth
Apr 19, 1956
Gender
Male
Current Plan Effective Date
Jan 7, 2018 - Dec 31, 9999
Relationship to Subscriber
Self
Member ID: R987654321
Group Number: 111
BlueCross BlueShield of New Mexico
Payer: OTHER BLUE PLANS-BCBSNM
Messages
Either the patient's ID, name, date of birth, or address in the response does not match the information sent in the request. The response reflects the correct information. To avoid future errors in submission, please update this information in your computer system.
Other or Additional Payer Information
No additional payer information provided.
Provider Information
Requesting Provider
Name:
Category: Requesting Provider
NPI:
FILTER BY NETWORK
Non-Participating
Participating
Preferred
All Networks
Plan Maximums and Deductibles
Health Benefit Plan Coverage - 30
Information / Details
Individual
Out Of Pocket
Preferred
Plan / Product: BASIC
$6,500 / Calendar Year(s)
$6,376.37 Remaining
-$123.63 Year to Date
Benefit Information
Expand
Chiropractic - 33
Dental Care - 35
Diagnostic Medical - 73
Emergency Services - 86
Hospital - 47
Auth Info Available
Hospital - Emergency Accident - 51
Hospital - Emergency Medical - 52
Hospital - Inpatient - 48
Auth Info Available
Hospital - Outpatient - 50
Auth Info Available
Medical Care - 1
Mental Health - MH

Private - BCBS FEDERAL

Registered

Name as Stated on Policy [required]

Policy Number or SSN [required]

R

Effective Date [required]

01-02-2024

Expiration Date

__-__-____

Policy Holder Sex [required]

Date Of Birth [required]

Primary Care Provider

CD Name

Holder's Employer Info

Status

Employer

Holder's Address

Street [required]

City [required]

State [required]

Zip Code [required]

Phone Number

Insurer Information

Group Name/Number

BCBS FEDERAL - 0FEPNM

Coverage Type

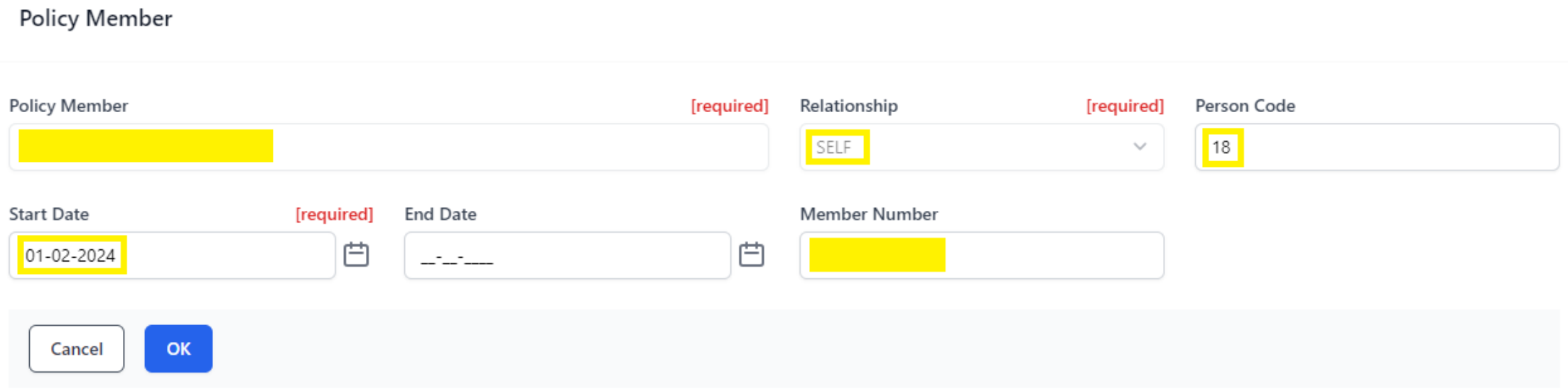
Card Copy on File

Policy Members

Add

MEMBER NAME	START DATE	END DATE	RELATIONSHIP	
	01-02-2024		SELF	Edit | Remove

Discard Save


Policy Member
Policy Member
[required]
Relationship
[required]
Person Code
SELF
18
Start Date
[required]
End Date
Member Number
01-02-2024
__-__-____
Cancel
OK

VETERANS

TRICARE ACTIVE DUTY

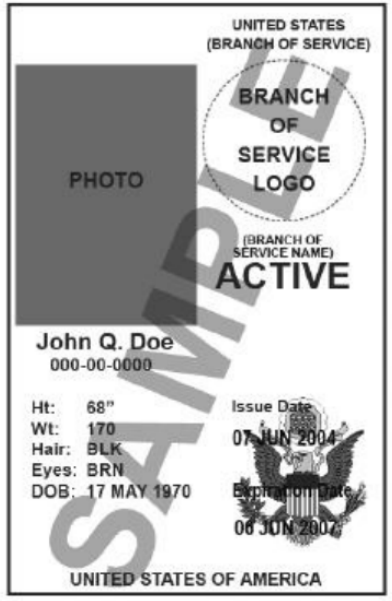
TRICARE FOR LIFE

VETERANS ADMINISTRATION

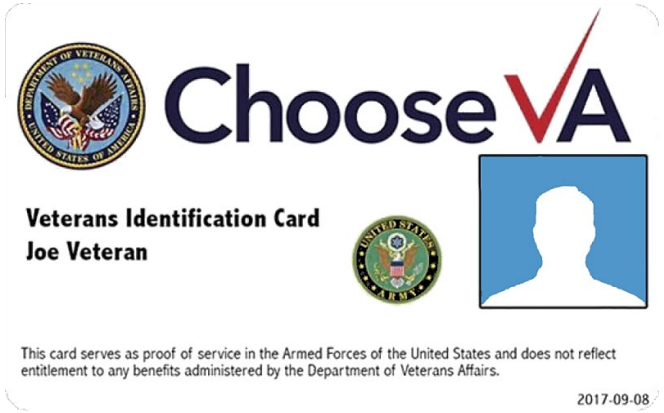
VETERANS MEDICAL BENEFIT PLAN

Uniformed Services Identification Card - Active Duty

Uniformed Services Identification Card - Active Duty Family Member



Common Access Card



COMMISSIONED CORP

COMMISSIONED OFFICER
- NONBENEFICIARY
- BENEFICIARY

DEPENDENTS OF COMMISSIONED OFFICER
- NONBENEFICIARY
- BENEFICIARY

BENEFICIARY MEDICAL PROGRAM (BMP)

WORKER'S COMPENSATION

Workers' Compensation is insurance that provides cash benefits and/or medical care for workers who are injured or become ill as a direct result of their job. Employers pay for this insurance, and shall not require the employee to contribute to the cost of compensation.

What does workers' comp cover?

- Medical Expenses
- Ongoing Care Costs
- Lost Wages
- Funeral Expenses

The Workers Comp Claims Process:

- ❑ Employees report work injury to supervisor immediately.
- ❑ Employee seeks medical treatment.
- ❑ HR files claim with the workers' comp insurance.
- ❑ Medical provider submits claim(s) to workers' comp insurance.
- ❑ Insurer approves or denies the claim.

WORKERS COMP VERIFICATION SHEET

TAX ID NPI RX NPI RX NCPDP/NABP

PATIENT INFORMATION

EMPLOYEE NAME		HRN	**MALE FEMALE**
MAILING ADDRESS		SSN	DOB
CITY	STATE	ZIP	PHONE NUMBER
EMPLOYER NAME		EMPLOYMENT STATUS **FULL PART UNEMP UNK RETIRED**	RETIREMENT DATE
CITY	STATE	ZIP	PHONE NUMBER

INJURY INFORMATION

DATE OF INJURY	DESCRIPTION OF INJURY	
REPORTED TO EMPLOYER **YES NO PENDING**		
DIAGNOSIS	ICD-9/ICD-10 CODE	
PROCEDURE	CPT CODE	

CLAIM INFORMATION

CLAIM NUMBER		EFFECTIVE DATE	TERM DATE
WORKERS COMP NAME		GROUP NAME	GROUP NUMBER
CLAIMS ADDRESS (PO BOX or STREET)		TAX ID	CLAIM STATUS
CITY	STATE	ZIP	FILING LIMIT
VERIFICATION NUMBER	PRECERT NUMBER		PRECERT REQUIRED **INPT HOSP OUTPT PROCS OTHER**
ADJUSTER'S NAME	ADJUSTER'S NUMBER		FAX NUMBER
NOTES			
REP'S NAME	VERIFIED BY		DATE

PAGE 1 OF 2

TAX ID NPI RX NPI RX NCPDP/NABP

PAGE 2 OF 2

NAME	HRN

COVERAGE INFORMATION

INSURER COVERS **MEDICAL MENTAL HEALTH DENTAL RX EYE**			COVERAGE TYPE **PPO POS HMO OTHER**
POLICY NUMBER			COORDINATION OF BENEFITS – SEQUENCE AS: **PRIMARY SECONDARY TERTIARY OTHER**
EFFECTIVE DATE			TERM DATE
INSURER NAME			GROUP NAME
CLAIMS ADDRESS (POB or STREET)			GROUP NUMBER
CITY	STATE	ZIP	FILING LIMIT
VERIFICATION NUMBER	PRECERT NUMBER		PRECERT REQUIRED **INPT OUTPT PROCS OTHER**
ADDITIONAL INFO			
18 Self / 01 Spouse / 19 Child / 21 Unknown / 39 Organ Donor / 40 Cadaver Donor / 53 Life Partner / G8 Other Relationship			
REP'S NAME	VERIFIED BY		DATE

COVERAGE INFORMATION

MEDICAL MENTAL HEALTH DENTAL RX EYE			**PPO POS HMO OTHER**
POLICY NUMBER			**PRIMARY SECONDARY TERTIARY OTHER**
EFFECTIVE DATE			TERM DATE
INSURER NAME			GROUP NAME
CLAIMS ADDRESS (POB or STREET)			GROUP NUMBER
CITY	STATE	ZIP	FILING LIMIT
VERIFICATION NUMBER	PRECERT NUMBER		**INPT OUTPT PROCS OTHER**
ADDITIONAL INFO			
REP'S NAME	VERIFIED BY		DATE

THIRD-PARTY LIABILITY

A legal action brought by a THIRD-PARTY against an insured party for damages or legal costs related to an incident or dispute. In the insurance industry, this type of claim is often used in motor vehicle accidents, medical malpractice, product liability cases, slip and falls.

INDIAN HEALTH SERVICES

FEDERAL MEDICAL CARE RECOVERY ACT (FMCRA) CASES

- Notification by patient or legal team representative
- Entered into FMCRA system
- Medical records and billing information are requested and released to patient or legal team representative
- Processed as NonRPMS payment

NONBENEFICIARY

"Are you an enrolled member of a United States Federally recognized tribe?"

If the answer is "No"

INELIGIBLE – OBTAIN GUARANTOR INFORMATION

SERVICE UNIT
Patient Financial Responsibility Statement

I am responsible for any medical services provided to me (patient) by , necessary expenses of medical care, examination and / or treatment.

I understand that willfully and knowingly making or using a false certificate with the intent of defrauding the United States Government, is punishable by a fine of $10,000 or imprisonment for 5 years, or both (18 U.S. Code 1001).

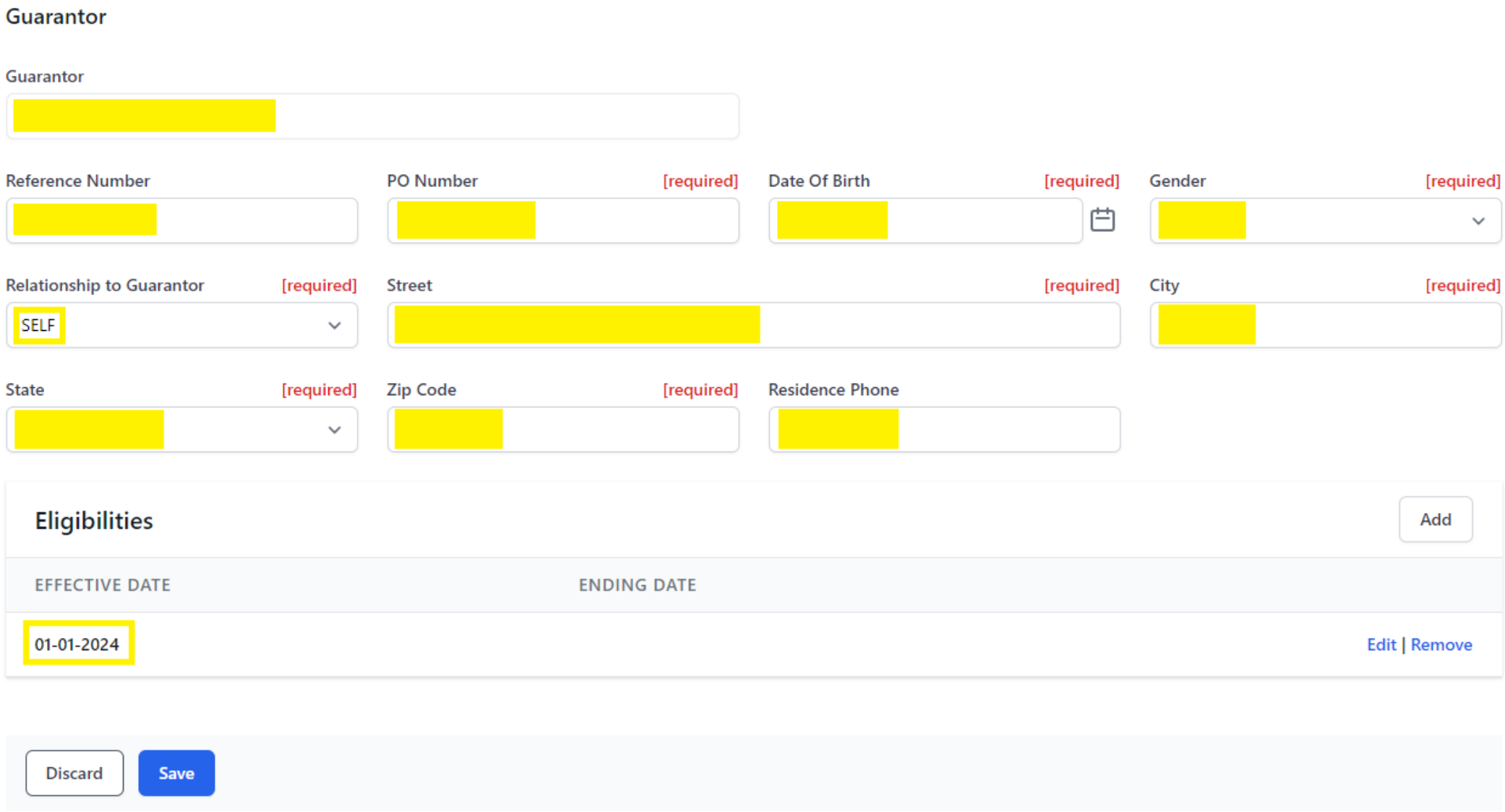
SIGNATURE OF PATIENT OR REPRESENTATIVE

PATIENT'S IDENTIFICATION / ADDRESSOGRAPH

DATE OF ADMISSION / DATE OF SERVICE:

INSTRUCTIONS: Prepare in triplicate. Copy to be given to patient. Original copy to be placed in Patient's Financial Folder. Second copy to be forwarded to Patient Registration Supervisor for tracking.

COLLECT SOCIAL SECURITY NUMBER OF GUARANTOR



PHARMACY POINT-OF-SALE (POS)

INSURER NAME	BIN	PCN	BILLED POS	D.0v or 5.1v
LOVELACE HEALTH PLAN	600428	2490000	Y	5.1
LOVELACE SALUD	600428	2490000	Y	5.1
SCI-LOVELACE	600428	2490000	Y	5.1
NEW MEXICO MEDICAID	610084	DRNMPROD	Y	5.1
D-PRESCRIPTION PATHWAY R	610468	UAFC	Y	5.1
MOLINA SALUD HEALTHCARE	610473		Y	5.1
SCI-MOLINA HEALTHCARE	610473		Y	5.1
EVERCARE OF NEW MEXICO	610494	9999	Y	5.1
EVERCARE RX	610494	9999	Y	5.1
OPTUM HEALTH OF NEW MEXICO	610494	9999	Y	5.1
PRESBYTERIAN SALUD	610593	SXC	Y	5.1
SCI-PRESBYTERIAN SALUD	610593	SXC	Y	5.1
D-HEALTHNET ORANGE 2-TIE	004336	ADV HDN	Y	5.1
D-HEALTHNET ORANGE 3-TIE	004336	ADV HDN	Y	5.1
D-HEALTHNET ORANGE OPT 1	004336	ADV HDN	Y	5.1
D-HEALTHNET ORANGE OPT 2	004336	ADV HDN	Y	5.1
D-HEALTHNET ORANGE OPT 3	004336	ADV HDN	Y	5.1
AMERIGROUP COMMUNITY CAR	004336	ADV	Y	5.1
D-SIERRARX	007382	SHS TQC	Y	5.1
VALUE OPTIONS RX	007417	RXI	Y	5.1
LOVELACE HEALTH PLAN RX	600428	02490000	Y	D.0
LOVELACE HEALTH SALUD RX	600428	02490000	Y	D.0
SCI-LOVELACE RX	600428	02490000	Y	D.0
FUTURE SCRIPTS	600428	03840000	Y	D.0
ARGUS	600428	02710000	Y	D.0
FUTURE SCRIPTS	600428	03840000	Y	D.0

NAME: 610084/DRNMPROD NM MEDICAID RX//
NCPDP VERSION: D.0//
BIN NUMBER: 610084//
PCN NUMBER: DRNMPROD//

600428/2490000 **LOVELACE HEALTH PLAN** *PRIVATE*
610468/UAFC **D-PRESCRIPTION PATHWAY** *PART D*
610494/9999 **OPTUM HEALTH OF NEW MEXICO** *PRIVATE*

PRIOR-AUTHORIZATION AND PRE-CERTIFICATION

INPATIENT ADMISSIONS

OUTPATIENT PROCEDURES

RADIOLOGY

BEHAVIORAL HEALTH

PHYSICAL THERAPY

PRECERTIFICATION SHEET

TAX ID NPI RX NPI RX NCPDP/NABP

PATIENT INFORMATION

NAME	HRN	SSN	DOB

POLICY HOLDER'S INFORMATION

NAME	HRN	SSN	DOB
MAILING ADDRESS		PHONE NUMBER	

COVERAGE INFORMATION

INSURER COVERS **MEDICAL MENTAL HEALTH DENTAL RX EYE**		COVERAGE TYPE **PPO POS HMO OTHER**	
POLICY NUMBER		COORDINATION OF BENEFITS – SEQUENCE AS: **PRIMARY SECONDARY TERTIARY OTHER**	
INSURER NAME		EFFECTIVE DATE	TERM DATE
CLAIMS ADDRESS (POB or STREET)		GROUP NAME	GROUP NUMBER
CITY	STATE	ZIP	FILING LIMIT
VERIFICATION NUMBER	PRECERT NUMBER		PRECERT REQUIRED **INPT OUTPT PROCS OTHER**
ADDITIONAL INFO 18 Self / 01 Spouse / 19 Child / 21 Unknown / 39 Organ Donor / 40 Cadaver Donor / 53 Life Partner / G8 Other Relationship			
REP'S NAME	VERIFIED BY		DATE

ADMISSION/PROCEDURE INFORMATION

ADMISSION/PROCEDURE DATE		OTHER SERVICE TYPE	DATE OF SERVICE
DIAGNOSIS/PROCEDURE		ICD-9/ICD-10 CODE or CPT CODE	
SERVICE	WARD	PROVIDER NAME	PROVIDER PHONE NUMBER
REFERENCE/AUTH NUMBER		REP'S NAME	
UTILIZATION REVIEW NURSE NOTIFIED		DATE	
ADDITIONAL INFO			
COMPLETED BY		DATE	

PRECERTIFICATION SHEET

TAX ID NPI RX NPI RX NCPDP/NABP

PATIENT INFORMATION

NAME	HRN	SSN	DOB	AGE

ADMISSION/PROCEDURE INFORMATION

ADMIT/PROCEDURE DATE	OTHER SERVICE TYPE	DATE OF SERVICE
DIAGNOSIS/PROCEDURE	ICD-9/ICD-10 or CPT CODE	
SERVICE / WARD	PROVIDER NAME	PROVIDER PHONE NUMBER

INSURER & REVIEW INFORMATION

INSURER NAME	INSURER PROVIDER NUMBER (Other than Tax ID or NPI)
POLICY HOLDER'S NAME	PRECERT NUMBER
POLICY NUMBER	REVIEW NUMBER (OPTION and/or EXTENSION)
REFERENCE NUMBER	REVIEW NURSE
1ST REVIEW	APPROVED THROUGH
2ND REVIEW	APPROVED THROUGH
3RD REVIEW	APPROVED THROUGH

PMH

TREATMENT PLAN, HISTORY NOTES, MEDICATION

3RD PARTY ORDER OF SEQUENCE
~NO MEDICARE COVERAGE INVOLVED~

GENERAL ORDER OF SEQUENCE

1. PRIVATE INSURANCE
2. TRICARE (UNITED HEALTH MILITARY)
3. STATE MEDICAID
4. VMBP

IF PT HAS PI UNDER SELF AND SP

1. PT'S PRIVATE INSURANCE
2. SP'S PRIVATE INSURANCE
3. TRICARE (UNITED HEALTH MILITARY)
4. STATE MEDICAID
5. VMBP

PT'S WITH MORE THAN ONE PRIV INS

(Example: Pt is retired from Mckinley County Schools and has BCBS of NM with retiree program and is currently employed with Chuska Schools and has SRT. ***Most current employer with PI will be prime and retiree account will be secondary***. Therefore, SRT is primary, then BCBS of NM secondary. If pt is not working with either, then it is whichever insurance pt had the longest that is primary.)

1. PRIV INS UNDER CURRENT/ACTIVE EMPLOYER
2. PRIV INS UNDER PREVIOUS EMPLOYER
3. TRICARE (UNITED HEALTH MILITARY)
4. STATE MEDICAID
5. VMBP

CHILD WITH PI UNDER BOTH PARENTS

(Follow "***Birthday Rule – Use parent's DOB to determine who is primary. Parent with the DOB that comes first by Month and Day will be primary, Parent with DOB that comes thereafter is the secondary.***")

1. PARENT'S PRIV INS (example: **6/12**/1963) – DOB 1st within the year by MM/DD. Disregard YR.
2. PARENT'S PRIV INS (example: **8/16**/1961) – DOB 2nd within the year by MM/DD. Disregard YR.
3. TRICARE (UNITED HEALTH MILITARY)
4. STATE MEDICAID

3RD PARTY ORDER OF SEQUENCE
~WHEN MEDICARE COVERAGE IS INVOLVED~

EMPLOYED w/ ACTIVE GROUP PI UNDER EMPLOYER

1. PRIVATE INSURANCE
2. MEDICARE
3. TRICARE (UNITED HEALTH MILITARY)
4. STATE MEDICAID
5. VMBP

RETIRED w/ UNEMPLOYED/RETIRED/UNINSURED SP or NO SP

1. MEDICARE
2. PRIVATE INSURANCE
3. TRICARE (UNITED HEALTH MILITARY)
4. STATE MEDICAID
5. VMBP

RETIRED w/ RETIRED and INSURED SP (Both pt and sp on sp's PI)

1. MEDICARE
2. PT'S PRIVATE INSURANCE
3. SP'S PRIVATE INSURANCE
4. TRICARE (UNITED HEALTH MILITARY)
5. STATE MEDICAID
6. VMBP

RETIRED w/ EMPLOYED and INSURED SP (Both pt and sp on sp's PI)

1. SP PRIVATE INSURANCE
2. MEDICARE
3. PT'S PRIVATE INSURANCE (if applicable)
4. TRICARE (UNITED HEALTH MILITARY)
5. STATE MEDICAID
6. VMBP

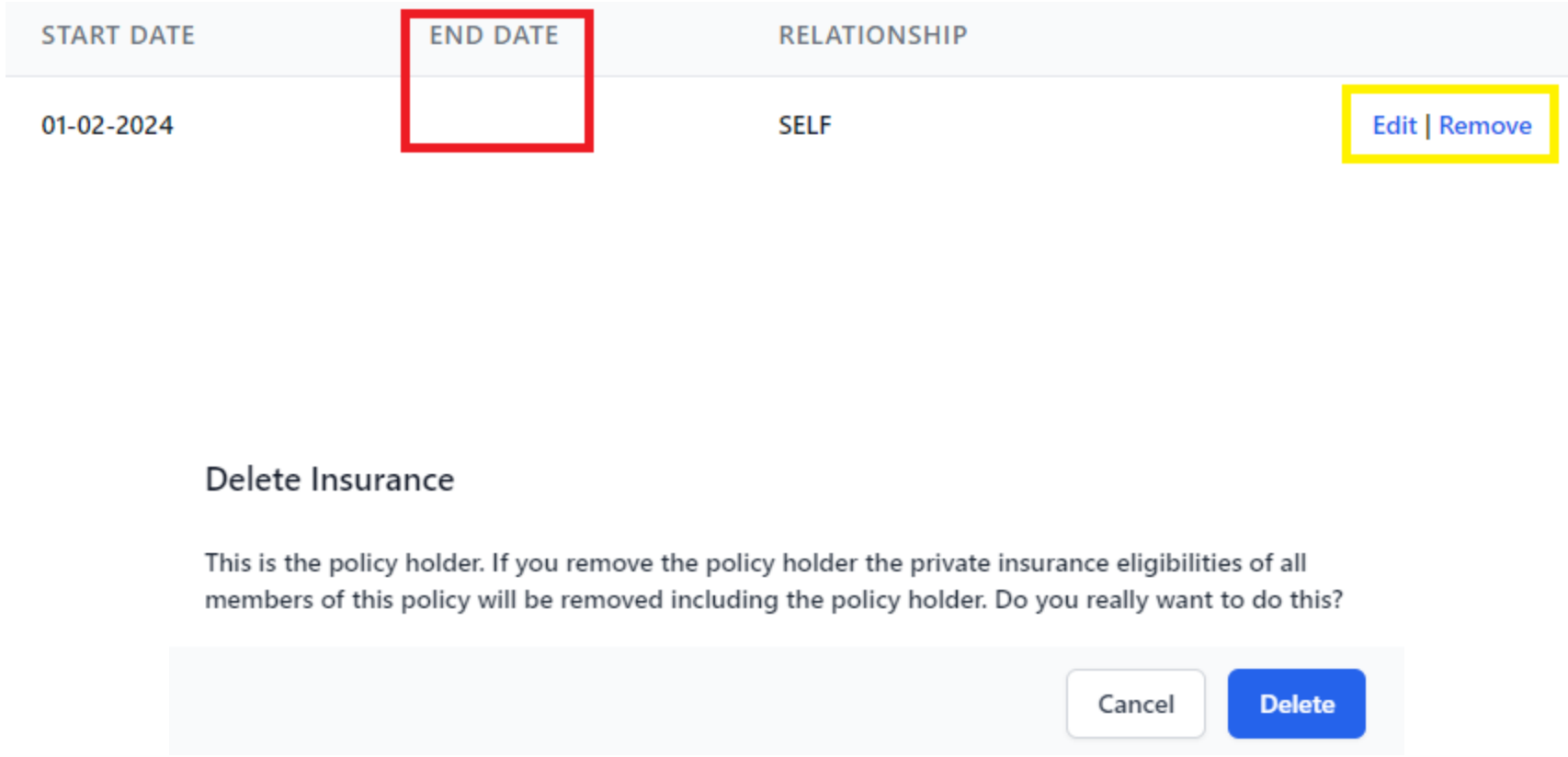
PATIENTS ADMITTED TO SKILLED NURSING FACILITY CENTER

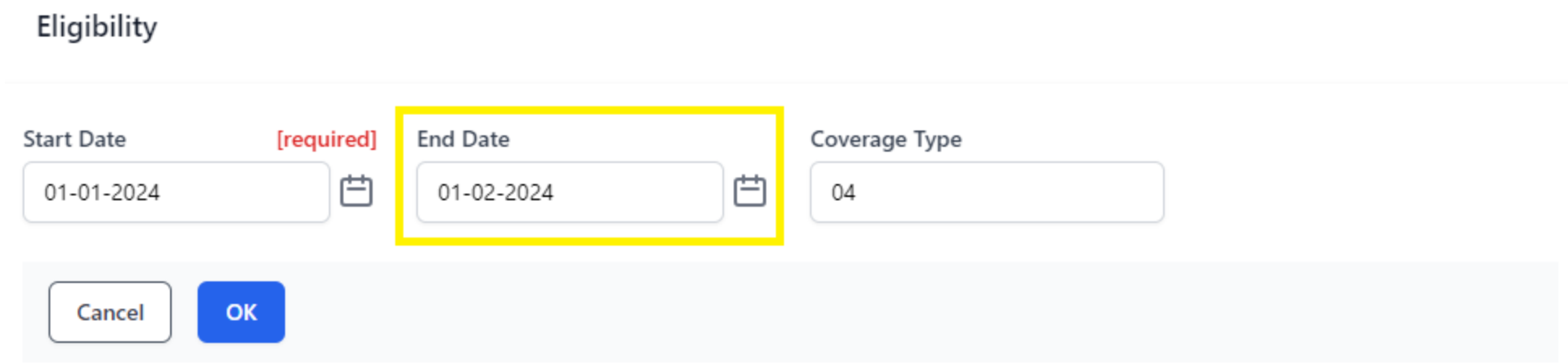
1. SNF (verify patient admitted to SNF.)
2. MEDICARE
3. PRIVATE INSURANCE
4. TRICARE (UNITED HEALTH MILITARY)
5. STATE MEDICAID
6. VMBP

REMOVE & DELETE

- ✓ALWAYS INSERT AN END DATE
- ✓ALSO DELETE SEQUENCING

NOW YOU MAY REMOVE OR DELETE ENTRY


START DATE
END DATE
RELATIONSHIP
01-02-2024
SELF
Edit | Remove
Delete Insurance
This is the policy holder. If you remove the policy holder the private insurance eligibilities of all members of this policy will be removed including the policy holder. Do you really want to do this?
Cancel
Delete


Eligibility
Start Date
[required]
01-01-2024
End Date
01-02-2024
Coverage Type
04
Cancel
OK

REPORTS

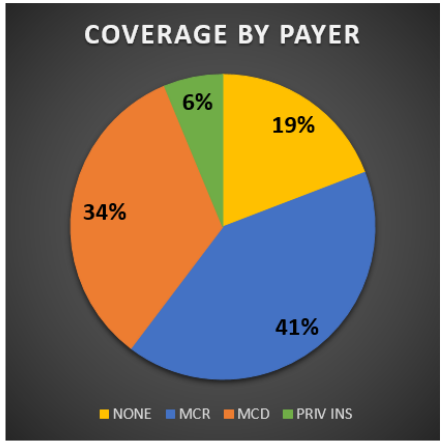
VGEN REPORT
^VGEN P PREDEFINED ORDER (THE ORIGINAL ORDERING) S SEARCH ALL VISITS ENTER DATE SPAN PREVIOUSLY DEFINED REPORT? N// CHOOSE N AT SELECT CHOOSE THE FOLLOWING REPORT:
SELECT **76** CLINIC TYPE OPTION **2** LIST ALL CLINIC TYPES **Q**UIT SELECT **81** VISIT DATE, **1** PATIENT NAME, **3** CHART NUMBER, **5** SEX, **12** AGE, **16** VETERAN, **98** LOCATION, **51** THIRD PARTY ELIGIBILITY, **53** VMBP, **74** PHR HANDOUT, **75** PHR ACCESS QUIT QUIT
HOME: **0;999;99999** ENTER RAW LOG SESSION **NAME.TXT** ENTER ENTER END RAW LOG SESSION OPEN IN EXCEL UNDER DATA FROM TEXT

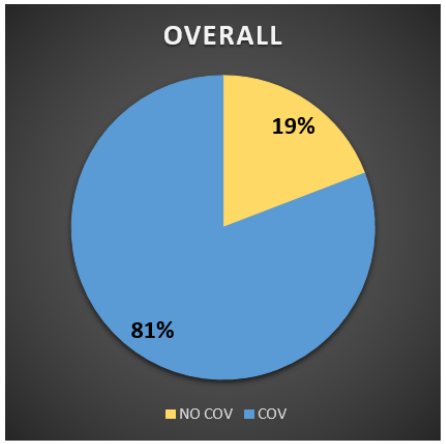
File Home Insert Page Layout Formulas Data Review View Acrobat Tell me what you want to do...

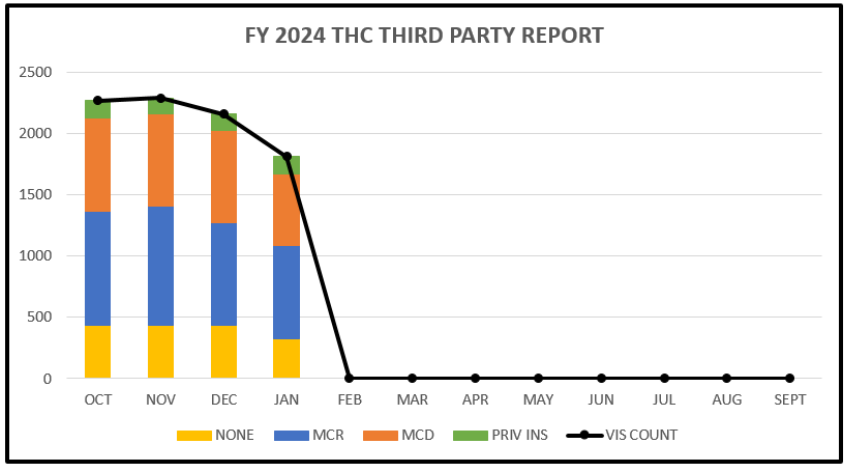
DOS	NAME	GS	HRN	SEX	AG	VETERAN	LOCATION	PAYER	PAYER	VMBP PAYER	PHR HANDOUT	PHR ACCESS
1/2/2024		THC		MALE	71	NO	TOHATCHI HEALTH	<none>			Yes PHR Handout	0
1/2/2024		THC		FEMALE	77	NO	TOHATCHI HEALTH	MEDICARE	MEDICAID		Yes PHR Handout	0
1/2/2024		THC		FEMALE	83	NO	TOHATCHI HEALTH	MEDICARE			Yes PHR Handout	0
1/2/2024		THC		MALE	73	YES	TOHATCHI HEALTH	MEDICARE	PRVT INS	UNITED CONCORDIA CO INC	Yes PHR Handout	0
1/2/2024		THC		MALE	40	NO	TOHATCHI HEALTH	PRVT INS		BCBS FEDERAL RX	Yes PHR Handout	0
1/2/2024		THC		MALE	76	NO	TOHATCHI HEALTH	MEDICARE			Yes PHR Handout	0
1/2/2024		THC		FEMALE	59	NO	TOHATCHI HEALTH	<none>			Yes PHR Handout	0
1/2/2024		THC		FEMALE	56	NO	TOHATCHI HEALTH	MEDICAID	PRVT INS	BCBS FEDERAL RX	Yes PHR Handout	0
1/2/2024		THC		MALE	61	YES	TOHATCHI HEALTH	MEDICARE	PRVT INS	HUMANA DENTAL CLAIMS	Yes PHR Handout	0
1/2/2024		THC		MALE	57	NO	TOHATCHI HEALTH	<none>			Yes PHR Handout	0
1/2/2024		THC		MALE	74	NO	TOHATCHI HEALTH	MEDICARE			Yes PHR Handout	0
1/2/2024		THC		FEMALE	63	NO	TOHATCHI HEALTH	MEDICAID			Yes PHR Handout	0
1/2/2024		THC		FEMALE	37	NO	TOHATCHI HEALTH	MEDICAID			Yes PHR Handout	Yes PHR Access
1/2/2024		THC		FEMALE	57	NO	TOHATCHI HEALTH	PRVT INS		DELTA DENTAL OF NEW MEXIC	Yes PHR Handout	0
1/2/2024		THC		FEMALE	82	NO	TOHATCHI HEALTH	MEDICARE	MEDICAID		Yes PHR Handout	0
1/2/2024		THC		MALE	64	NO	TOHATCHI HEALTH	<none>			Yes PHR Handout	0
1/2/2024		THC		FEMALE	45	--	TOHATCHI HEALTH	MEDICAID	PRVT INS	PRESBYTERIAN RX MEDICAID	Yes PHR Handout	0
1/2/2024		THC		MALE	58	YES	TOHATCHI HEALTH	<none>			Yes PHR Handout	0
1/2/2024		THC		FEMALE	33	NO	TOHATCHI HEALTH	<none>			Yes PHR Handout	0
1/2/2024		THC		MALE	47	NO	TOHATCHI HEALTH	MEDICAID			Yes PHR Handout	0
1/2/2024		THC		FEMALE	72	NO	TOHATCHI HEALTH	MEDICARE	PRVT INS	UHC INTEGRATED SERVICES	Yes PHR Handout	0
1/2/2024		THC		MALE	43	NO	TOHATCHI HEALTH	MEDICAID			Yes PHR Handout	0
1/2/2024		THC		FEMALE	89	NO	TOHATCHI HEALTH	MEDICARE	MEDICAID		Yes PHR Handout	0
1/2/2024		THC		FEMALE	77	NO	TOHATCHI HEALTH	MEDICARE	MEDICAID		Yes PHR Handout	0
1/2/2024		THC		FEMALE	61	NO	TOHATCHI HEALTH	MEDICAID			Yes PHR Handout	0
1/2/2024		THC		MALE	73	NO	TOHATCHI HEALTH	MEDICARE			Yes PHR Handout	0
1/2/2024		THC		FEMALE	61	NO	TOHATCHI HEALTH	MEDICAID	PRVT INS	PRESBYTERIAN RX MEDICAID	Yes PHR Handout	0
1/2/2024		THC		FEMALE	69	NO	TOHATCHI HEALTH	MEDICARE	MEDICAID	PRESBYTERIAN RX MEDICAID	Yes PHR Handout	0
1/2/2024		THC		MALE	6	NO	TOHATCHI HEALTH	MEDICAID			Yes PHR Handout	0
1/2/2024		THC		FEMALE	61	NO	TOHATCHI HEALTH	MEDICAID	PRVT INS	PRESBYTERIAN RX MEDICAID	Yes PHR Handout	0
1/2/2024		THC		FEMALE	61	NO	TOHATCHI HEALTH	MEDICARE	PRVT INS	HUMANA DENTAL CLAIMS	Yes PHR Handout	0
1/2/2024		THC		FEMALE	58	NO	TOHATCHI HEALTH	MEDICARE	MEDICAID		Yes PHR Handout	0
1/2/2024		THC		FEMALE	16	NO	TOHATCHI HEALTH	MEDICAID			Yes PHR Handout	0
1/2/2024		THC		FEMALE	60	NO	TOHATCHI HEALTH	<none>			Yes PHR Handout	No PHR Access

OVERALL THIRD PARTY COVERAGE

	VIS COUNT	NONE	MCR	MCD	PRIV INS
OCT	2268	438	930	761	139
NOV	2292	439	974	751	128
DEC	2162	432	843	755	132
JAN	1811	328	763	584	136
FEB	0				
MAR	0				
APR	0				
MAY	0				
JUN	0				
JUL	0				
AUG	0				
SEPT	0				
FY 2024	8533	1637	3510	2851	535
%		19%	41%	33%	6%





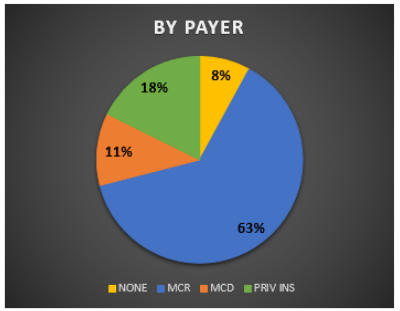


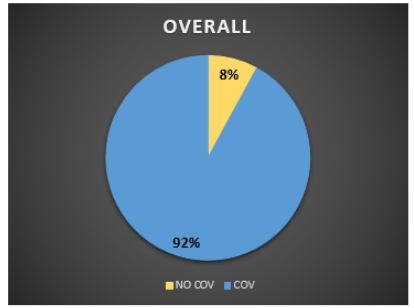
BY PAYER	
NONE	1637
MCR	3510
MCD	2851
PRIV INS	535

OVERALL	
NO COV	1637
COV	6896

VETERANS

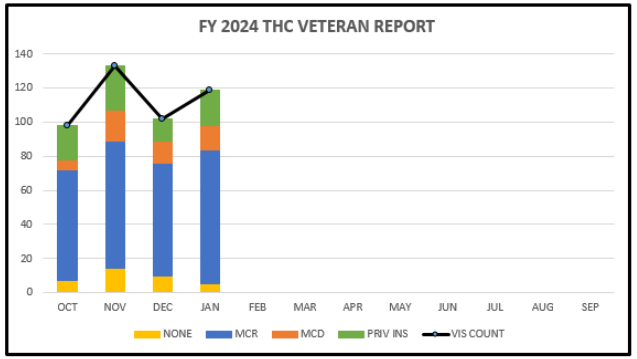
	VIS COUNT	NONE	MCR	MCD	PRIV INS
OCT	98	7	65	6	20
NOV	133	14	75	18	26
DEC	102	10	66	13	13
JAN	119	5	79	14	21
FEB					
MAR					
APR					
MAY					
JUN					
JUL					
AUG					
SEP					
FY 2024	452	36	285	51	80
%		8%	63%	11%	18%





BY PAYER	
NONE	36
MCR	285
MCD	51
PRIV INS	80

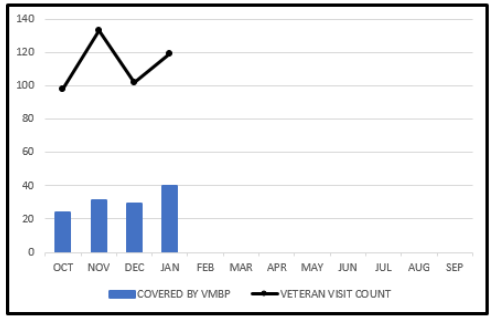
OVERALL	
NO COV	36
COV	416



VETERAN VISIT COUNT	
VETERAN VISITS	452
TOTAL VISITS	8533
VETERAN %	5%

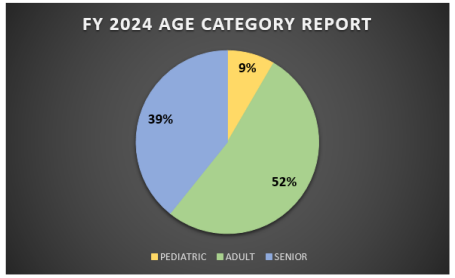
	VETERAN VISIT COUNT	COVERED BY VMBP
OCT	98	24
NOV	133	31
DEC	102	29
JAN	119	40
FEB		
MAR		
APR		
MAY		
JUN		
JUL		
AUG		
SEP		
TOTAL	452	124

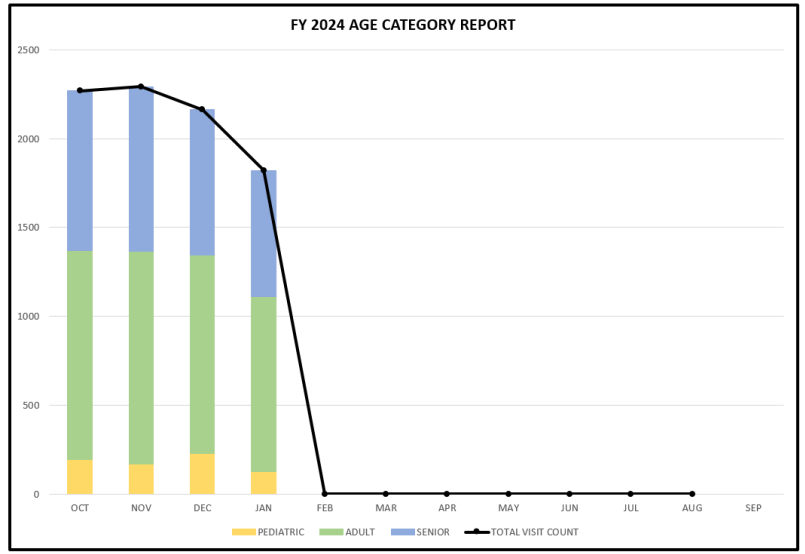
VETERANS COVERED BY VMBP 27%



AGE CATEGORY REPORT

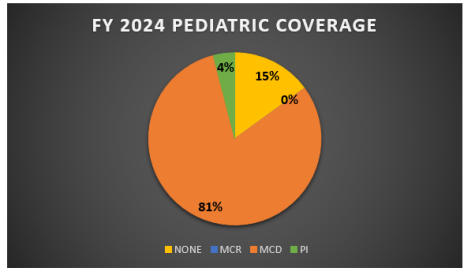
	PEDIATRIC	ADULT	SENIOR	TOTAL VISIT COUNT
OCT	195	1175	898	2268
NOV	170	1195	927	2292
DEC	228	1118	816	2162
JAN	127	984	709	1820
FEB				0
MAR				0
APR				0
MAY				0
JUN				0
JUL				0
AUG				0
SEP				
FY 2024 TOTAL	720	4472	3350	8542

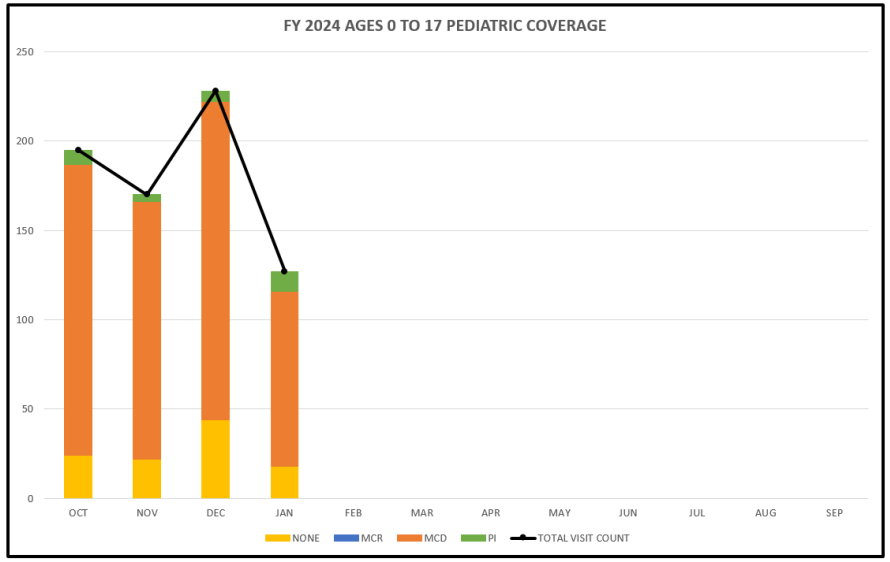




PEDIATRIC

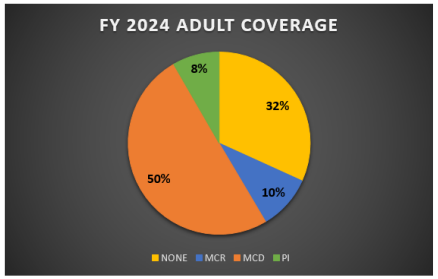
	TOTAL VISIT COUNT	NONE	MCR	MCD	PI
OCT	195	24	0	163	8
NOV	170	22	0	144	4
DEC	228	44	0	178	6
JAN	127	18	0	98	11
FEB					
MAR					
APR					
MAY					
JUN					
JUL					
AUG					
SEP					
FY 2024 TOTAL	720	108	0	583	29

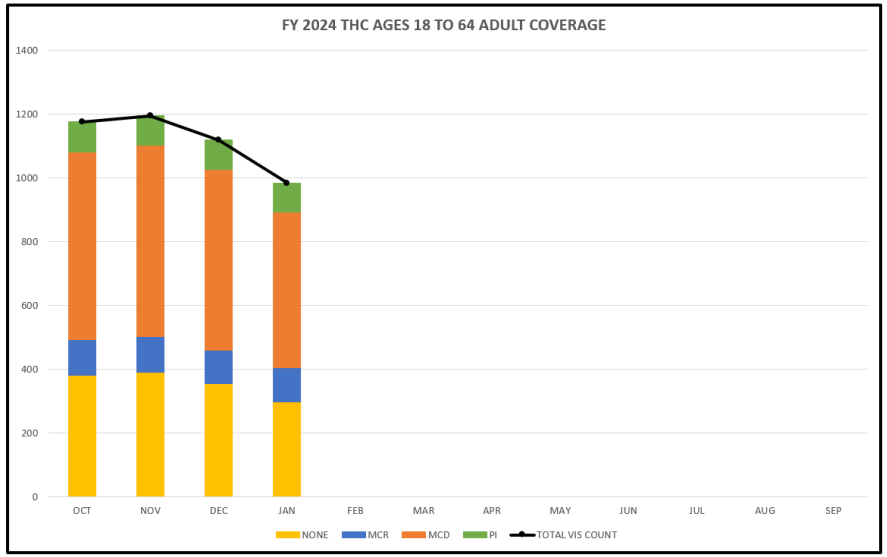




ADULT

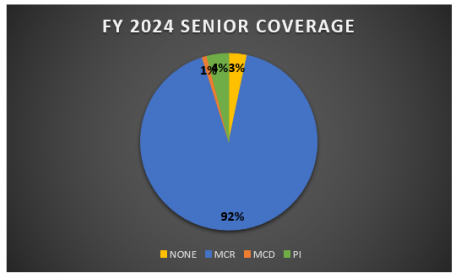
	TOTAL VIS COUNT	NONE	MCR	MCD	PI
OCT	1175	381	111	588	95
NOV	1195	389	112	601	93
DEC	1118	355	103	567	93
JAN	984	296	108	488	92
FEB					
MAR					
APR					
MAY					
JUN					
JUL					
AUG					
SEP					
FY 2024 TOTAL	4472	1421	434	2244	373

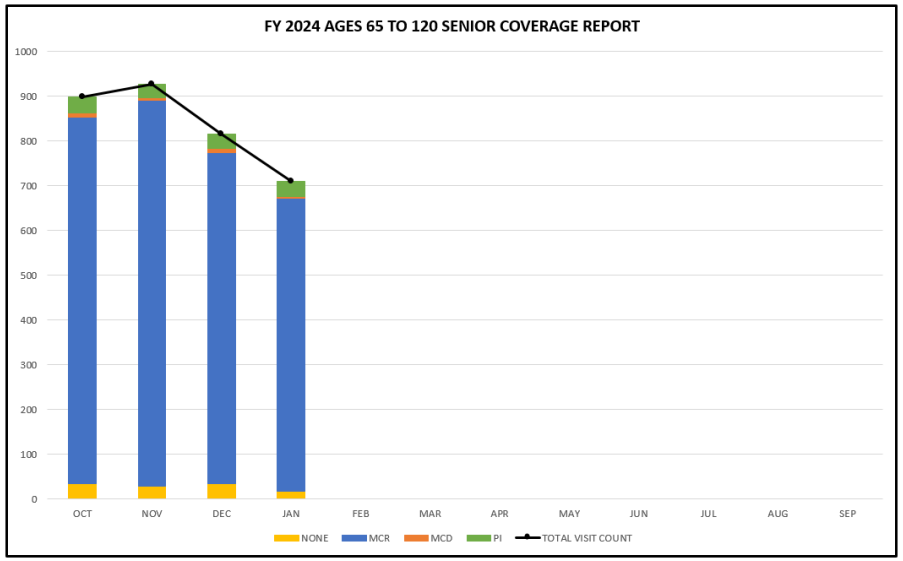




SENIOR

	TOTAL VISIT COUNT	NONE	MCR	MCD	PI
OCT	898	33	819	10	36
NOV	927	28	862	6	31
DEC	816	33	740	10	33
JAN	709	17	655	4	33
FEB					
MAR					
APR					
MAY					
JUN					
JUL					
AUG					
SEP					
FY 2024 TOTAL	3350	111	3076	30	133





OBJECTIVES

- ✓ Why does IHS collect THIRD-PARTY information?
- ✓ What is the revenue used for?
- ✓ How does it benefit our patients?
- ✓ Health Insurance Terms
- ✓ Types of Insurers
- ✓ Important Forms for Billing
- ✓ Explanation of Insurance Verification Process
- ✓ Coordination of Benefits & Sequencing
- ✓ Prior Authorizations
- ✓ Reports

SEQUENCING OR COORDINATION OF BENEFITS FOR REGISTRATION

LESLIE A BOWSTRING-REECE, CPC, CPCO
Business Office Coordinator, Bemidji Area, IHS
March 13, 2024

What is Coordination of Benefits?

When a patient has two (or more) insurance plans those plans will work together to pay claims. This is called coordination of benefits. A few general rules define how each of those payers will pay on the claim. Both companies will work together to:

- Avoid duplicate payments by making sure the two plans don't pay more than the total amount of the claim.
- Establish which plan is primary (pays first) and which plan pays secondary.
- This practice helps reduce the cost of insurance premiums.

Determining Coordination of Benefits

Birthday Rule

- Whose birthday falls first in a calendar year? This becomes primary payer (claim is submitted to this payer first)
  - Partner 1: April – BCBS - Primary
  - Partner 2: August – Aetna - Secondary
- If both partners have the same birthday, then subscriber with longest coverage becomes primary.

Determining COB - MSP

- Medicare Secondary Payer Guidelines
  - Disability
  - Workman's Comp

- BCRC Benefits Coordination & Recovery Center (BCRC) is responsible for recovery of mistaken liability, no-fault or worker's compensation collectively referred to as NonGroup Health Plans. This is a situation where we did not obtain the information of these types of claims using MSP guidelines, and Medicare made a payment as primary when they were not primary.

Sequencing Payers

Determines primary payer, secondary payer, etc.

Determined by Category

- Medical
- Dental
- Optometry
- Pharmacy
- Mental Health

SCENARIOS FOR PRACTICE!

SCENARIO:

Mr. Oppenheimer is a 52-year old executive actively employed with Hilton Hotels. He is in town conducting a new employee orientation when he has chest pain. He has United Healthcare and Delta Dental through his employer and Mutual of Omaha through his wife's employer. Determine his coordination of benefits for today's visit.

ANSWER:

United Health Care

Mutual of Omaha

Would you ask for, and then enter his dental information?

- Yes. That way your information is complete. Consider Dental billing.
  - This is a personal preference item, and a suggestion to gather as much as you can

SCENARIO Option A

Ms. Barbie is a 27 -year old free-lance marketing representative for Mattel. On the job for 20 days, she schedules an appointment to see a doctor for a runny nose. You interview her and she states that she signed up for coverage with Aetna but doesn't have an insurance card to show her benefits. She does, however, give you her dental card. You call for additional information and find out that Ms. Barbie's health insurance doesn't take effect until 90 days of employment. Ms. Barbie is nonIndian, how would you determine her coordination of benefits for today's visit?

Would you add her dental insurance?

ANSWER:

Self-Pay

- Patient is a nonben, responsible for her bill. Fill out patient responsibility paperwork. Try to collect payment now.
- Add dental insurance only if the clinic will continue to see her as a patient. (Perhaps the clinic is a tribal or urban clinic and nonbens are seen.)

SCENARIO Option B

Ms. Barbie is a 27 -year old free-lance marketing representative working for Mattel. On the job for 20 days, she schedules an appointment to see a doctor for a runny nose. You interview her and she states that she signed up for coverage with Aetna but doesn't have an insurance card to show her benefits. She does, however, give you her dental card. You call for additional information and find out that Ms. Barbie's health insurance doesn't take effect until after 90 days of employment. Ms. Barbie is a Minnesota Chippewa Tribal member enrolled with the Leech Lake Band of Ojibwe. She presents her Enrollment Card. How would you determine her coordination of benefits for today's visit, what happens to her account?

Would you add her dental insurance?

ANSWER:

Beneficiary

- Patient is a beneficiary.
- Add dental insurance so information is complete and up to date.

SCENARIO:

Mrs. Chief Being is a healthy 71 -year old retiree from the Indian Health Service health system. She receives Medicare Part A and Part B as well as benefits from her retirement plan with Federal BCBS of South Dakota. She is seeing her primary care physician today for her annual check-up.

Is she required to fill out an MSP (Medicare Secondary Payer) form, and why is it important to get this information?

ANSWER:

She is not working, so coverage is Medicare Part B first, then BCBS would be secondary.

- The MSP points you in this direction as it asks questions to assist in determining who is primary.

Yes – complete that MSP every 90 days for outpatient. (System prompt).

- New training through our MAC (Novitas) has begun to emphasize completing this **every** time. *This has become a "best practice" where the information is obtained without fail.*

SCENARIO:

Mr. High Cloud presents himself at your facility with a large laceration (cut) on the palm of his right hand. Wound is managed with a wrapping. When you interview him, he indicates that this happened while he was cutting wood at work at the SU facility. There is construction going on. What additional questions would you ask Mr. High Cloud?

ANSWER:

Enter as Workman's Comp. Communicate with your billing team, **know your process**.

Contact employer and obtain information regarding WC carrier. Obtain claim number. Add all information that you have collected to Page 9.

Make sure "First Report of Incident" report is on file.

EXAMPLE. Facility has a lot of construction going on. Two work comp cases happened within a couple of weeks. One WC injury was nonben worker. The other WC injury was a beneficiary. WC was not identified in either case. Packet was prepared to turn to debt mgmt for nonben. With beneficiary patient, charges were adjusted as beneficiary. Company identified on Page 9 and was called, he stated what about the other injury? That is when we identified the beneficiary second patient.

SCENARIO:

Mrs. Humphrey is a 37-year old homemaker that is participating in a Breast and Cervical Cancer research program that is funded by her state. As a participant, she is required to get a mammogram as well as other related procedures. She is also covered under her husband's Advantage HMO plan. She is receiving a mammogram today. Determine her coordination of benefits for today's visit.

ANSWER:

Bill Breast and Cervical cancer organization. As a condition of participation, she must have the procedures and they are payable through the organization.

Check with your organization's process, as there may be special requirements you may need to collect (income) for billing these state plans.

SCENARIO:

Mrs. Brown brings her 3-year old son, Cody for immunizations. Mrs. Brown is a 32 year-old secretary who carries the Great West Health plan through her employer. She indicates that Cody isn't covered under her health plan, but that he is covered under Mr. Brown's plan with AWHP. Cody is also enrolled in the State's Children Health Insurance Program. Determine Cody's coordination of benefits for today's visit.

ANSWER:

Bill Mr. Brown's plan first.

Children's Health Insurance Program for all services other than immunizations.

What is billable? All immunizations? Check with your facility (only for your own knowledge).

SCENARIO:

Ms. Flower is being seen in the walk -in clinic for an injured back. During the interview process you discover that she fell while shopping in a local grocery store. Ms. Flower does not have insurance, however, the store manager has verified her story. Determine her coordination of benefits for today's visit.

ANSWER:

Enter in the system as Third-Party Liability.

Confirm the carrier to be billed with the store

Confirm with your facility the process for billing Third -Party Liability, Tortfeaser or FMCRA cases. There is a difference in process for federal facilities, and tribal facilities, possibly urbans as well. You are responsible for identifying and starting the process.

Resources

National Association of Insurance Commissioners (NAIC) Website

www.naic.org

Centers for Medicare/Medicare Services (CMS) COB Website

www.cms.hhs.gov

Medicare Secondary Payer (MSP) Manual Website

www.cms.hhs.gov

Medicare Coordination of Benefits Website

www.cms.hhs.gov/medicare/cob/attorneys/att_home.asp

Medicare Secondary Payer (MSP) Form Website –Other Insurer Tool

www.rimedicare.org

QUESTIONS?

CONTACT INFORMATION

FAWNIA FRANKLIN, BUSINESS OFFICE MANAGER

GALLUP SERVICE UNIT – TOHATCHI HEALTH CENTER

FAWNIA.FRANKLIN@IHS.GOV

(505) 733-8212 OFFICE

PRONOUNS: SHE/HER/HERS

LESLIE ANNE BOWSTRING -REECE

BUSINESS OFFICE COORDINATOR – BEMIDJI AREA

LESLIE.REECE@IHS.GOV

(218) 444-0509 OFFICE

(218) 553-1489 CELL

PRONOUNS: SHE/HER/HERS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