

State of California— Health and Human Services Agency



### Health Insurance Premium Payment Assistance Medical Out–of–Pocket Program

# Program Benefits

#### Who is covered?

(1.) ADAP clients who are also receiving health insurance premium payment assistance through the OA-HIPP program.

(2.) Spouses and/dependents of HIPP clients, who are also enrolled in ADAP.

#### What is covered?

Outpatient expenses that count towards the insurance plan's out-of-pocket maximum, which are the copayment, coinsurance, and deductible for medical care as part of the plans covered benefits. **Note**: All claim submissions must be for expenses incurred during the client's active HIPP eligibility period.

# **Billing and Claim Submissions**

#### Obtaining required supporting documentation for services received

- (1.) Provide the medical provider with the PAI-CDPH HIPP Program identification card.
- (2.) Request a medical billing statement or invoice from the provider.
- (3.) After the client's appointment, the client should receive an Explanation of Benefits (EOB) from their insurance company.

**Note**: If the client does not receive an EOB, they should contact their insurance company to request one. If the client has difficulty obtaining an EOB, please contact PAI directly at (877) 495-0990 for further instruction on acceptable submission documentation.





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#### Submitting a Claim to PAI

To submit a claim to PAI, the following must be included:

- (1.) Medical Out-of-Pocket Claim Form (See attachment 1),
- (2.) Billing statement/invoice (See attachment 2)
- (3.) EOB (See attachment 3)

**<u>Note</u>**: One Medical Out-of-Pocket Claim Form is required for each date of service and provider. For example, if the client visits multiple providers on the same day, they will need to submit each claim individually.

Claims can be sent using one of the following methods:

- (1.) Fax: (860) 560-8225
- (2.) Email: CDPH\_MBM\_Fax@pooladmin.com
- (3.) Standard mail:

P A I - CDPH 628 Hebron Avenue, Suite 100 Glastonbury, CT 06033

#### **Reimbursement**

#### How will the client be reimbursed?

The HIPP program pays the reimbursement directly to the provider. If the client is required to pay at the time of service, one of the following should occur:

- (1.) Provider issues the reimbursement directly to the client, or
- (2.) Provider will apply the reimbursement as a credit on the client's account.





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If the client is not required to pay at the time of service, one of the following should occur:

- (1.) The provider should work directly with PAI and submit the claim on the client's behalf for payment, or
- (2.) The client submits the claim and PAI will submit the payment on the client's behalf.

# **Claim Denial**

#### What could cause a claim to be denied?

- (1.) Ineligible dates of service
- (2.) Unauthorized expense: not covered by medical insurance
- (3.) Any expense that is listed as "Not Covered by the Primary Insurer". For example, elective out patient surgeries may not be covered by primary insurance and would not be reimbursable by CDPH.
- (4.) Unauthorized expense: medical service is out of network
- (5.) Unauthorized expense: Inpatient service
- (6.) Service does not count toward your annual out of pocket maximum
- (7.) Client name does not match the invoice
- (8.) Supporting documentation not provided within 21 days of the Information Request letter being sent
- (9.) Cost of Service does not match the supporting documentation
- (10.) Other

**Note**: If a client receives a denial letter, they have 20 days from the date of the letter to file an appeal.







# **Request for More Information (See Attachment 4)**

# A client may receive a request for more information in the following circumstances:

- (1.) Supporting documentation was not provided
- (2.) Supporting documentation is incomplete. Please send provider billing invoice
- (3.) Supporting documentation is incomplete. Please send insurance Explanation of Benefits
- (4.) Supporting documentation is illegible
- (5.) Supporting documentation does not match date of service
- (6.) Supporting documentation does not match submitted request
- (7.) Supporting documentation does not match requested claim reimbursement amount
- (8.) Other

**Note**: A client has 21 days from the date of the letter to provide PAI with the requested documentation.

**Reminder:** A provider is not obligated to waive any co-payments that are due at the time of service. If the client's provider does require payment at the time of service, the client is encouraged to ask the provider to contact PAI directly to discuss the program in more detail.

Additionally, in accordance with IRS guidelines, providers are required to submit completed W9s to PAI prior to PAI remitting payment. PAI will contact the provider to obtain the W9 if one is not already on file.



State of California— Health and Human Services Agency



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# Attachment 1: Sample Medical Out-of-Pocket Claim Form

JCDPH		205909	PA
Insurance Premium Pay	/ment Assistance Medic	al Out-of-Pocke	t Claim Form
Submitter must complete S documentation must be sent Fax: (860) 560-8225 Email: CDPH_MBM_F	to Pool Administrators, In	aim form AND su c. (PAI)	pporting
Mail: PAI-CDPH, 628	Hebron Ave., Suite 100, C	Blastonbury, CT	06033
If you have any questions Service at (877) 495-0990		n, please contac	t PAI Customer
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State of California— Health and Human Services Agency

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# Attachment 2: Sample Invoice

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State of California-Health and Human Services Agency



California Department of Public Health

# Attachment 3: Sample Explanation of Benefits (EOB)

#### Medical services payment detail as of 5/05/2017

Services provided for: Claim number Date claim received Provider Network status Patient account SAMPLE CLIENT 05/04/17 QUEST DIAGNOSTICS 1234 In-network 1234 Your health benefits paid You pay Amoust Amount due te Services Your tal voc o Day you Reason charged by your provider discounts your provider 🛲 Anthem Blue Cross paid Сорау + Deductible Coinsurance not covered (or may got care Services received cade -+ + + have gaid) 4/27/17 Venipuncture 068 22.50 20.4 2.10 0.00 2.10 0.00 0.00 0.00 2.1 135 4/27/17 Lab Hematology 086 42.18 35.24 6.94 0.00 5.94 D.90 0.90 0.00 6.94 135 4/27/17 Lab Immunology 065 135 240.85 188.92 41.93 30,97 10.98 0.90 0.00 9.00 10.98 4/27/17 Lab Immunology 866 183.35 159.65 33.66 33.86 0.00 0.80 0.00 0.00 0.0 4/27/17 Lab Panel 088 \$7.68 9,43 31.32 9.43 0.00 0.80 0.00 0.00 0.00 0.0 4/27/17 Lab Microbiology 066 103.49 72.17 31.32 0.00 0.00 0.C 066 72.16 31.32 75.93 0.00 0.00 0.00 4/27/117 Lab Microbiology 103,48 31.32 0.61 0.00 Ð.0 4/27/17 tab Microbiology 088 497.21 331.2 75.93 0.00 0.00 0.0 4/27/27 Lab Ammunology 066 95.6 83.81 11.81 11.81 0.60 0.00 0.00 0,08 8.0 1.285.78 1,041.34 Subtota 244.44 0.80 0.00 224.44 20.00 0.00 This provider is in your plan's network. This lets us use your in-network banefits to pay for overed services. Look for the "You pay" section above for what you owe. 135: THIS AMOUNT IS THE MEMBER'S COPAYMENT RESPONSIBILITY. DBG: THIS IS THE AMOUNT IN EXCESS OF THE MAXIMUM ALLOWED AMOUNT FOR A PARTICIPATING PROVIDER. THE MEMBER, THEREFORE, IS NOT RESPONSIBLE FOR THIS AMOUNT, Total for SAMPLE 1,285.78 1,041.34

224.44

20.00

Т

0.00

0.00

244.44

You can learn more about services shown here, including diagnosis and treatment codes and what they mean, Just call Member Services at 855-634-3381.

Page 3 of 7

0.00 20.00



State of California-Health and Human Services Agency



California Department of Public Health

# **Attachment 4: Sample Information Request Letter**





#### Sample Information Letter

Information Request

<First Name Last Name> <Address 1> <Address 2> <City, State, Zip>

Date < Month DD. YYYY>

Re: Claim Number: <Insert Claim number> Provider/Payee Name: <Insert Provider/Payee Name> Date of Service: <Insert Date of Service> Claim Request Amount: < Insert Claim Request Amount>

Dear <Insert First Name Last Name>,

This letter is to inform you that the evaluation of your reimbursement request for outpatient out of pocket medical costs submitted to the California Department of Public Health (CDPH) insurance premium payment assistance program has been delayed for the reason noted below.

Select one :( Common Reasons for information request to be selected from the administration system chosen from a system drop-down menu)

- · Supporting documentation was not provided
- Supporting documentation is incomplete. Please send provider billing invoice .
- Supporting documentation is incomplete. Please send insurance Explanation of Benefits
- Supporting documentation is illegible
- · Supporting documentation does not match date of service
- · Supporting documentation does not match submitted request
- Supporting documentation does not match requested claim reimbursement amount
- Other (An 80-character editable field will be available for input)

Acceptable types of supporting documentation must include; your name, the date of service, service provider name, the type of outpatient medical service you received, and your out of pocket cost. You may find this information on an invoice, claim, or an Explanation of Benefits. The documentation submitted must be legible. Always note the Claim Number <Insert Claim Number> on all supporting documents submitted that are associated with this request.

Please submit the required documentation to Pool Administrators Incorporated (PAI), using one of the following methods:

- 1. Fax: (860) 560-8225
- Email: CDPH\_MBM\_Fax@pooladmin.com
- Email: CDPH\_MBM\_Fax@pooladmin.com
   Mail: PAI-CDPH, 628 Hebron Avenue, Suite 100, Glastonbury, CT 06033

If you have any questions, please contact the PAI customer service team at (877) 495-0990. Your response is required within 21 days from the date of this letter. Otherwise, your claim will be denied.