Indian Health Service

Basic Patient Registration Data – Demographics & Eligibility

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ADRIAN LUJAN, OFFICE OF INFORMATION TECHNOLOGY

TOPICS

BILLING CLAIMS

REGISTRATION EDITOR

THIRD PARTY ELIGIBILITY

- INSURER ENTRY
- MEDICARE
- MEDICAID
- PRIVATE INSURANCE
- PRIOR AUTH
- WORKER'S COMP

BILLING CLAIMS

TYPES OF CLAIM FORMS

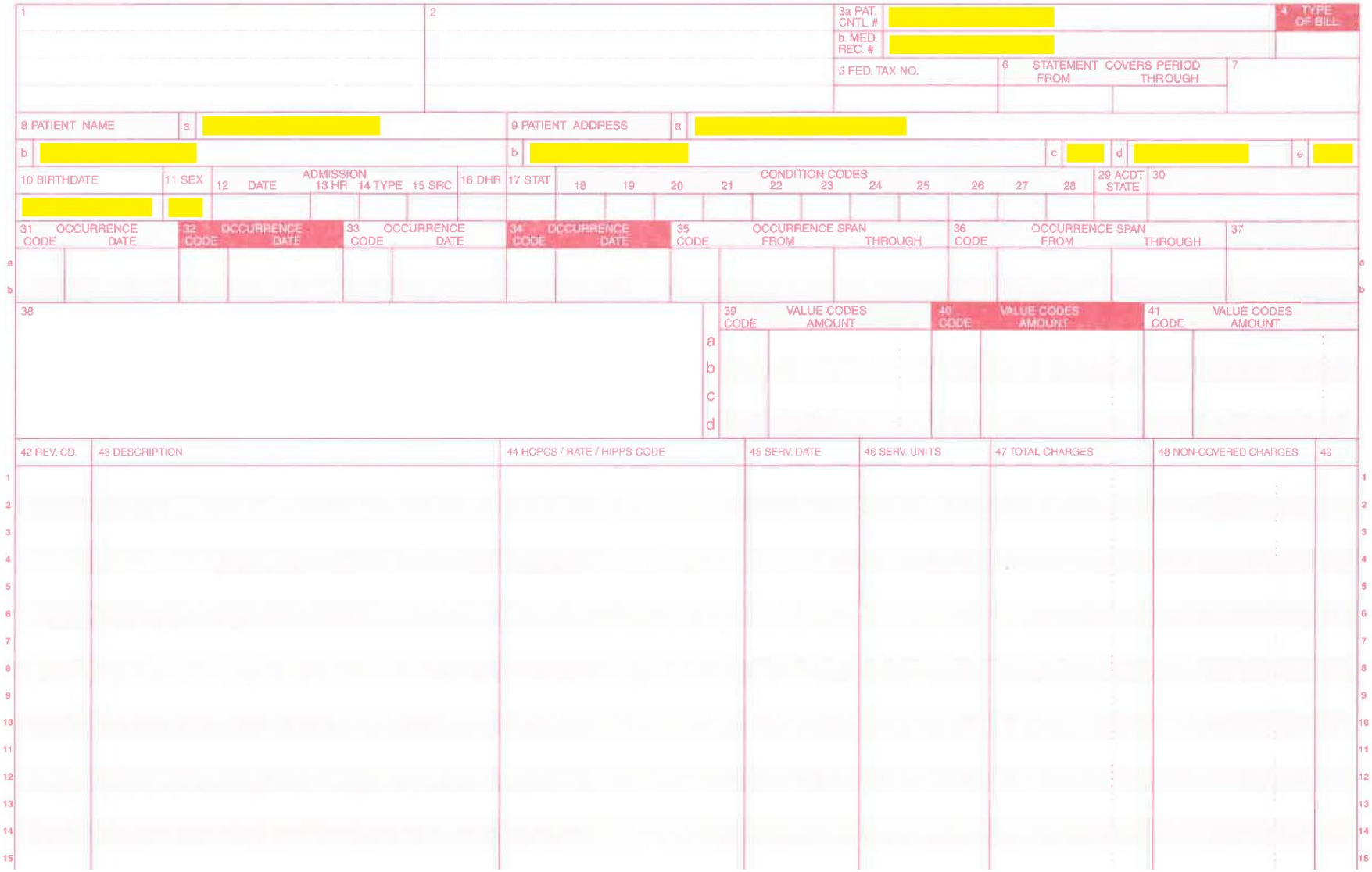
Paper
- UB-04
- CMS-1500 (02/12)
- ADA-2012
- NCPDP

Electronic
- 837 Institutional
- 837 Professional
- 837 Dental
- D.0

Purpose
- Main purpose is to submit charge, provider and other information needed to adjudicate services provided to the patient

- Registration demographics and eligibility can make up to 50% of the data on the form

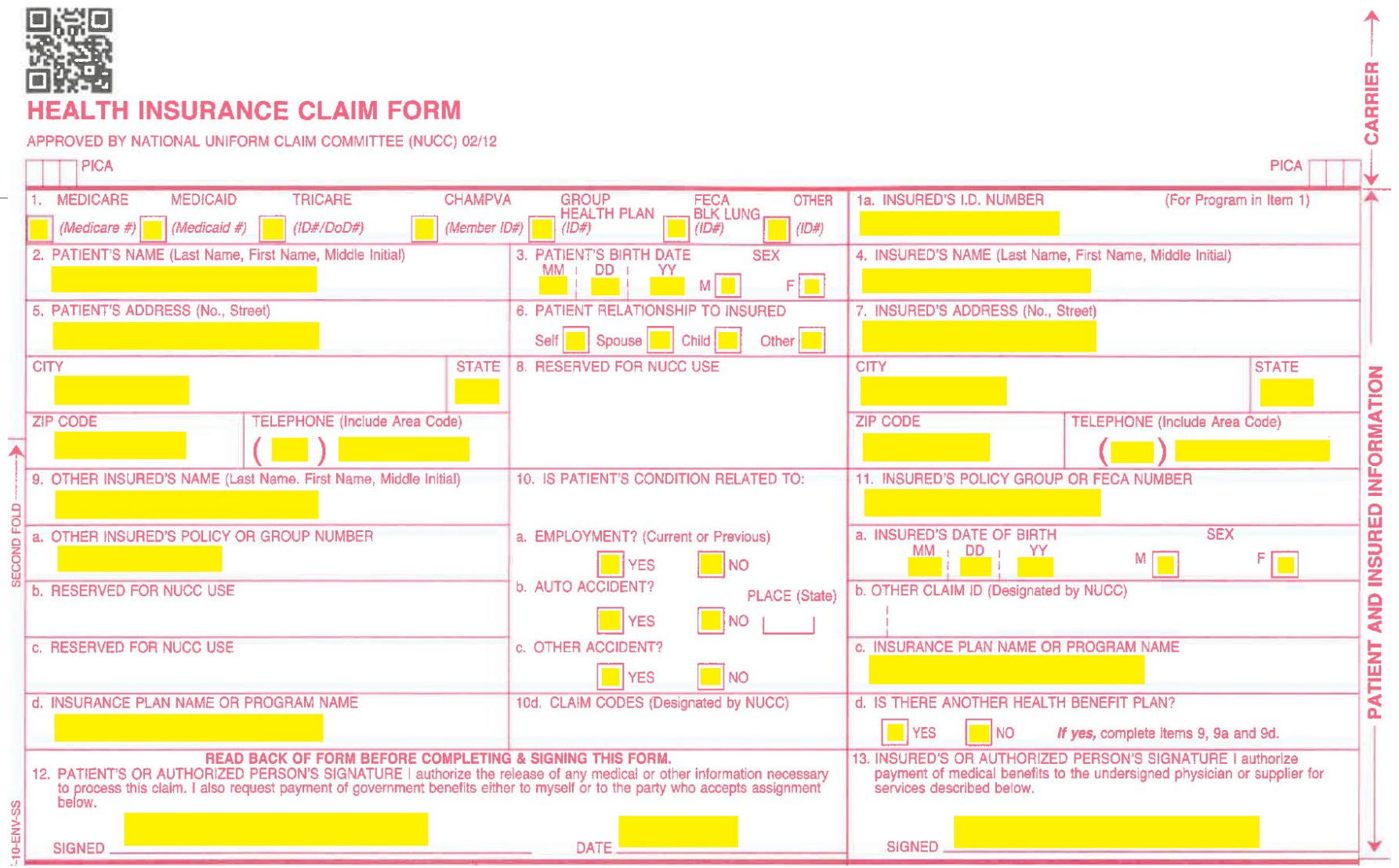
UB04


1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
a
9 PATIENT ADDRESS
a
b
b
c
d
e
10 BIRTHDATE
11 SEX
12 ADMISSION DATE
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
18 19 20 21 22 23 24 25 26 27 28
CONDITION CODES
29 ACDT STATE
30
31 CODE OCCURRENCE DATE
32 CODE OCCURRENCE DATE
33 CODE OCCURRENCE DATE
34 CODE OCCURRENCE DATE
35 CODE OCCURRENCE SPAN FROM THROUGH
36 CODE OCCURRENCE SPAN FROM THROUGH
37
a
b
38
39 CODE VALUE CODES AMOUNT
40 CODE VALUE CODES AMOUNT
41 CODE VALUE CODES AMOUNT
a
b
c
d
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

UB04


PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
74a OTHER PROCEDURE CODE DATE
74b OTHER PROCEDURE CODE DATE
74c OTHER PROCEDURE CODE DATE
74d OTHER PROCEDURE CODE DATE
74e OTHER PROCEDURE CODE DATE
75
76 ATTENDING NPI QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST
80 REMARKS
81CC a b c d
UB-04 CMS-1450
APPROVED OMB NO. 0938-0997
UB04L
NUBC
TFP24394485
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

CMS-1500



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

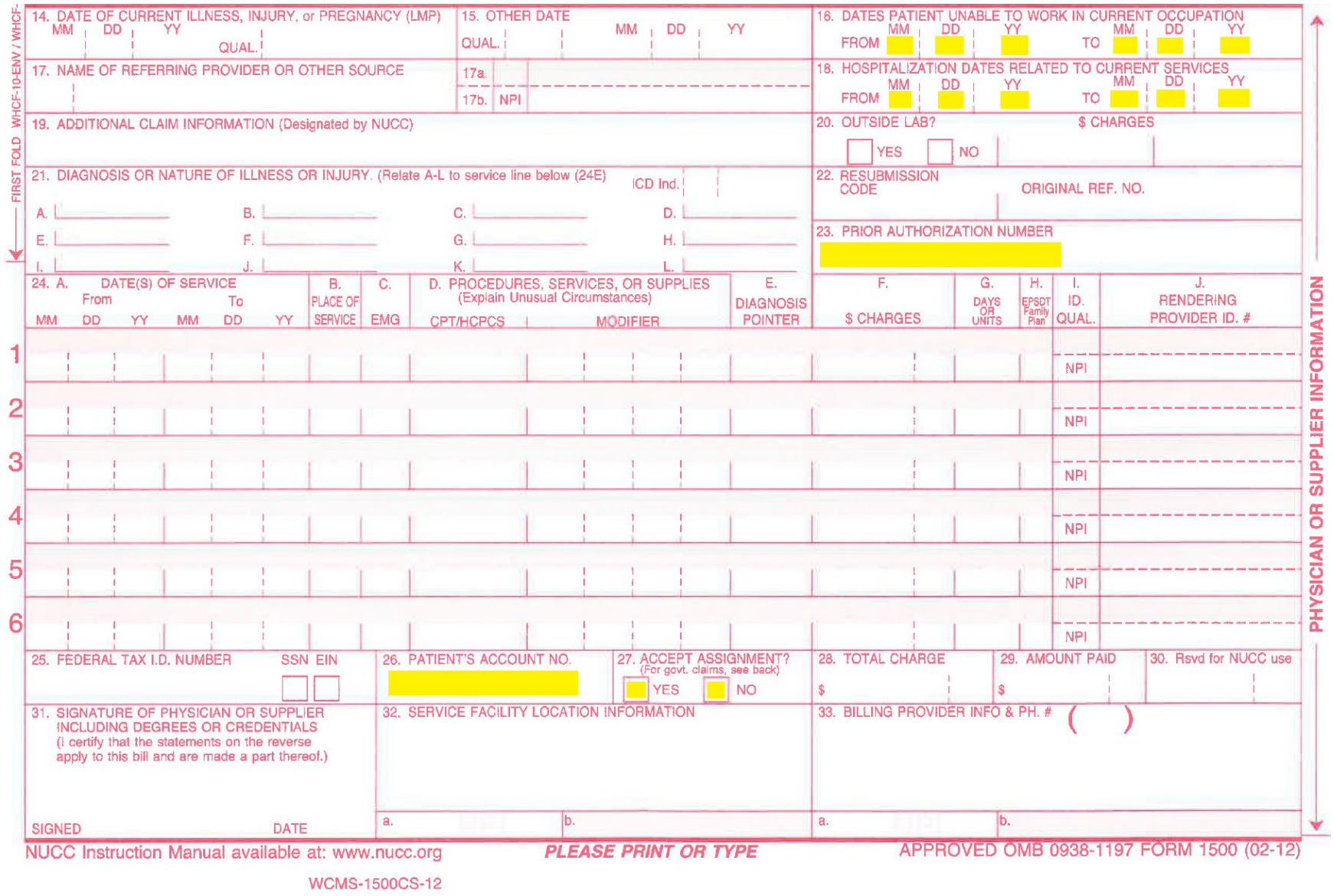
CARRIER

PATIENT AND INSURED INFORMATION

SECOND FOLD

10-ENV-SS

CMS-1500



FIRST FOLD WHCF-10-ENV / WHCF-

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. Rsvd for NUCC use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION a. b.
33. BILLING PROVIDER INFO & PH. # ( ) a. b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB 0938-1197 FORM 1500 (02-12)
WCMS-1500CS-12

REGISTRATION EDITOR

Basic Patient Registration Functions

Patient Registration Functions (This is not a complete list!)

- **Interviews** the patient (ask opened ended questions).
- Patient Registration **creates the patient record** and patient identification system. Inaccurate information can adversely affect other departments and cause unnecessary reworks by the BO staff and HIM staff.
- **Updates** the patient record on **every visit**, including but not limited to, demographic information and third party eligibility information.
- **Collects** third party resource information, verifies, enters and sequences.
- **Documents** the patient encounter.
- **Customer Service**: Registration staff are the first point-of-contact with the patient.

DEMO,PATIENT AD
6/27/1978 (45 YRS) - FEMALE

HRN: 130562
Eligibility Status: CHS & DIRECT
PCP: NOBLE,MICHAEL MD

Last Updated: 05/29/2024 By (BENALLY,EDWINA)
No Record Flags | Not Sensitive | No RHI | Active Insurance | UNS Veteran

Profile | Insurance | Prior Auth | Benefits Cases | Appointments | Print

- Demographics
- Address/Email/Internet
- Tribe and Eligibility Status
- Legal Name
- Preferred/Other Names
- HRN/Record Disposition
- SO/GI
- Emergency Contact
- Next of Kin
- Family Information
- Restricted Health Info
- Death Information
- Notice of Privacy Practices
- PHR Access
- Advance Directives
- Veteran Status
- Legal Documents
- AOB/ROI
- Record Flag
- Notes

Demographics

Edit

Demographics

Date of Birth	Birth Sex	Place of Birth
06-27-1978	FEMALE	GALLUP, NEW MEXICO

Marital Status	Religion	Social Security Number
SINGLE	OTHER	XXX-XX-0562

Employment

Employer	Spouse's Employer
CITY OF GALLUP, FULL-TIME	UNEMPLOYED

Ethnicity

NOT HISPANIC OR LATINO (SELF IDENTIFICATION)

Race

AMERICAN INDIAN OR ALASKA NATIVE (UNKNOWN)

Languages

Primary	Preferred	English Proficiency
ENGLISH	ENGLISH	WELL

Other Languages
NAVAJO

Migrant

Migrant Worker	Migrant Worker Type	Last Updated
NO		04-14-2010

Homeless

Homeless	Homeless Type	Last Updated
NO		04-14-2010

DEMO,PATIENT AD
6/27/1978 (46 YRS) - FEMALE

HRN: 130562
Eligibility Status: CHS & DIRECT
PCP: NOBLE,MICHAEL MD

Last Updated: 07/02/2024 By (FRANKLIN,FAWNIA D BOM)
No Record Flags | Not Sensitive | No RHI | Active Insurance | Veteran

Profile | Insurance | Prior Auth | Benefits Cases | Appointments | Print

- Demographics
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- Veteran Status
- Legal Documents
- AOB/ROI
- Record Flag
- Notes

Address/Email/Internet

Edit

Address	516 E NIZHONI BLVD GALLUP, NEW MEXICO, 87301 View Address History		
Present Community	GALLUP since 12-22-2005 View Community History		
Location of Home	GALLUP NM		
Phone	Residence 505-722-1000	Cell	Work
	Other		
Rx Patient Residence	HOME		
Email			
Permission to Send Generic Information	YES		
Preferred Method of Communication	LETTER		
Internet Access	YES - HOME,MOBILE DEVICE,WORK	Last Updated 05-29-2024	

Eligibility Status

PENDING VERIFICATION

- Categorically eligible patients includes beneficiaries and non-beneficiaries
- Incomplete record
- Proof of eligibility has been established, but the record is incomplete/missing documents

INELIGIBILE

- Patients who are not categorically eligible for services
- Not eligible for PRC

CHS&DIRECT

- Categorically eligible patients includes beneficiaries and non-beneficiaries
- Complete record
- Patient is eligible for PRC services
- Non-Indian pregnant women—must meet eligibility and PRC criteria

DIRECT ONLY

- Categorically eligible patients includes beneficiaries and non-beneficiaries
- Complete Record
- Not Eligible for PRC

Tribe of Membership

The TRIBE OF MEMBERSHIP field is updated with the Federal Register publishing the latest tribe listing

Unlisted Tribes may be requested but work through your Area Statistician to make the request to update the list

Other status

NON-INDIAN (AND NON-FED RECOGN	000
NON-INDIAN MEMBER OF IND. HOUS	970

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- SO/GI
- Emergency Contact
- Next of Kin
- Family Information
- Restricted Health Info
- Death Information
- Notice of Privacy Practices

Tribe and Eligibility Status

Edit

Classification/Beneficiary: INDIAN/ALASKA NATIVE

Eligibility

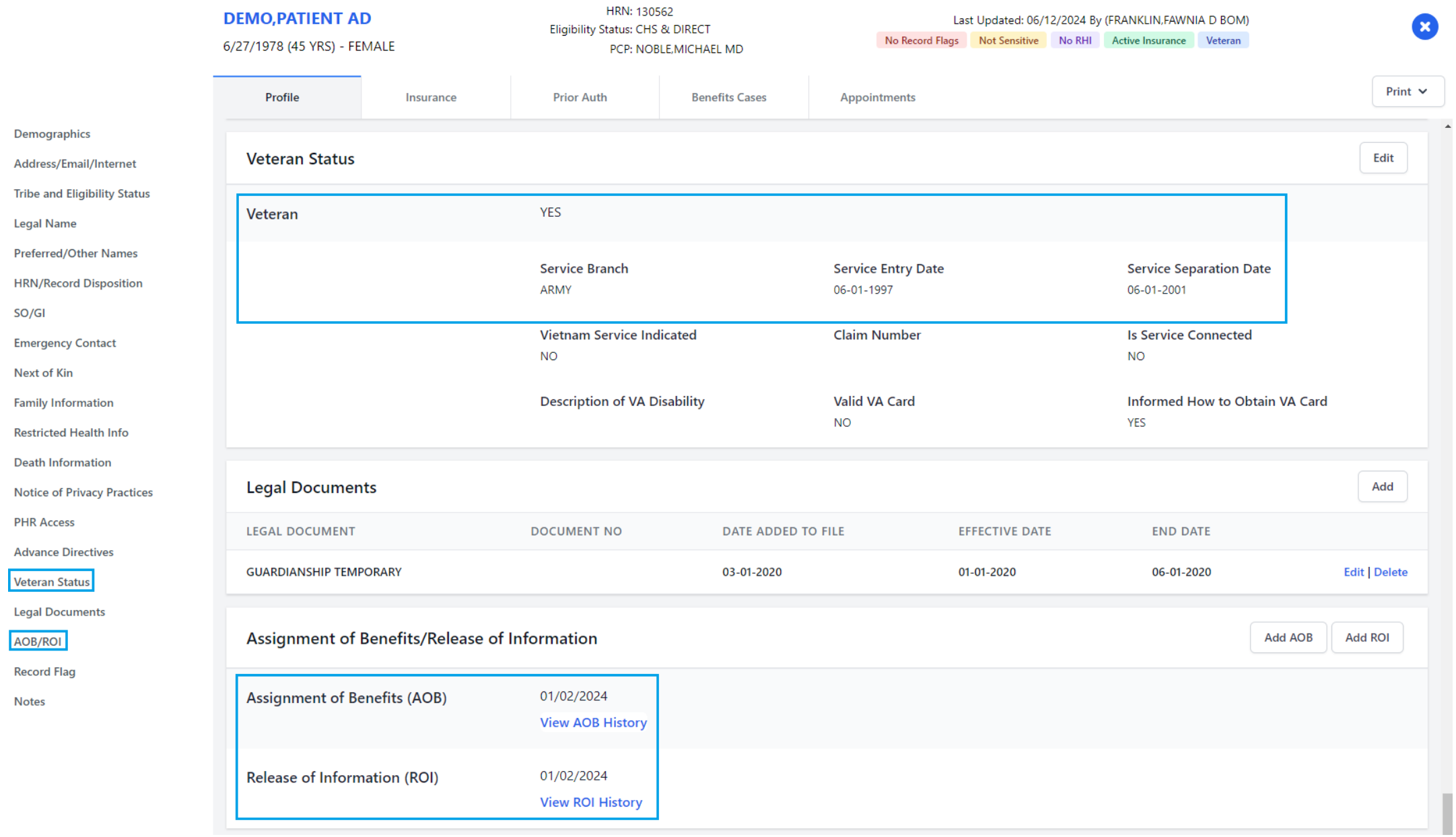
Eligibility Status	Reasons
CHS & DIRECT	ENROLLED MEMBER OF THE LOCAL TRIBE(S)/LIVES WITHIN CHSDA

Tribe

Tribe Of Membership	Indian Blood Quantum	Tribe Quantum
NAVAJO TRIBE, AZ NM AND UT	1/2	1/2

Tribal Enrollment Number

Other Tribes: ZUNI TRIBE, NM - 1/4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HRN/Record Disposition
SO/GI
Emergency Contact
Next of Kin
Family Information
Restricted Health Info
Death Information
Notice of Privacy Practices
PHR Access
Advance Directives
Veteran Status
Legal Documents
AOB/ROI
Record Flag
Notes
Veteran Status
Edit
Veteran
YES
Service Branch
ARMY
Service Entry Date
06-01-1997
Service Separation Date
06-01-2001
Vietnam Service Indicated
NO
Claim Number
Is Service Connected
NO
Description of VA Disability
Valid VA Card
NO
Informed How to Obtain VA Card
YES
Legal Documents
Add
LEGAL DOCUMENT
DOCUMENT NO
DATE ADDED TO FILE
EFFECTIVE DATE
END DATE
GUARDIANSHIP TEMPORARY
03-01-2020
01-01-2020
06-01-2020
Edit | Delete
Assignment of Benefits/Release of Information
Add AOB
Add ROI
Assignment of Benefits (AOB)
01/02/2024
View AOB History
Release of Information (ROI)
01/02/2024
View ROI History

THIRD PARTY ELIGIBILITY

Key Terms

Policy Holder

Name of the person that subscribes to third party coverage

Coverage Type

Used to describe the types of services covered under the patient's policy.
Dental, Medical, Prescription, etc.

Rate/Category Code

Defines the level of services the patient is covered for (Medicaid)

Guarantor

Individual who is financially responsible for services provided. Usually applies to Non-Beneficiary patients and minor children

Person Code

Identifies a dependent's relationship to the subscriber.

Types of Payers

Medicare – Title XVIII

Medicaid – Title XIX

State Children's Health Insurance Plan– Title XIX

State Children's Health Insurance Plan– Title XXI

Private Insurance Health Plans

Commissioned Officers

Veterans Administration

Workmen's Compensation

Third Party Liability

Others

Coordination of Benefits

Term used to assign a priority order to all available eligibility depending on services provided

Site has the ability to use this option

Currently, does not set the priority order of billing in Third Party Billing

- Claim generator sets the billing priority

INSURER ENTRY

DEMO,PATIENT AD

6/27/1978 (45 YRS) - FEMALE

HRN: 130562
Eligibility Status: CHS & DIRECT
PCP: NOBLE,MICHAEL MD

Last Updated: 06/12/2024 By (FRANKLIN,FAWNIA D BOM)

No Record Flags | Not Sensitive | No RHI | Active Insurance | 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	
DEMO,PATIENT [G] 516 E NIZHONI BLVD, GALLUP, NM 87301-1337	GUARANTOR	DEMO,PATIENT AD		123456789	07-05-2019		Active	Edit | Delete
NEW MEXICO MEDICAID PO BOX 26500, ALBUQUERQUE, NM 87125-6500 (800)299-7304	MEDICAID	DEMO,PATIENT AD	100	123456789	09-18-2023		Active	Edit | Delete
VA MEDICAL BENEFIT (VMBP) PO BOX 30780 ATTN IHS, TAMPA, FL 33630 (855)488-8441	PRIVATE	DEMO,PATIENT AD	PRIORITY GRP 2	987654321	01-01-2024		Active	Edit | Delete

NEW PAYER FORM – FORWARD TO BILLING TO BE ENTERED INTO TABLE MAINTENANCE

INSURER NAME	TAX ID	PAYER ID	BIN	PCN

TYPE OF COVERAGE

☐ MEDICAL ☐ DENTAL ☐ BEHAVIORAL HEALTH ☐ PHARMACY ☐ VISION

PROVIDER PHONE NUMBER	PRIOR AUTH NUMBER	FILING LIMIT

CLAIM ADDRESS

STREET OR MAILBOX ADDRESS

CITY	STATE	ZIP

Insurer

Name [required]

Insurer Type [required]

Please Select

- Please Select
- 3P LIABILITY
- CHAMPUS
- CHIP (KIDSCARE)
- FPL 133 PERCENT
- FRATERNAL ORG
- GUARANTOR
- HMO
- INDIAN PATIENT
- MCR MANAGED CARE
- MCR PART C
- MCR PART D
- MEDICAID FI
- MEDICARE FI
- MEDICARE HMO
- MEDICARE SUPPL
- NON-BEN (NON-INDIAN)
- PRIVATE
- STATE EXCHANGE PLAN
- TRIBAL SELF INSURED

Long Name

Street Address

City

State

Please Select

Zip Code

Contact Person

Billing Office

Billing City

Billing State

Please Select

Status [required]

BILLABLE

Rx Billing Status

Please Select

Discard Save

Insurer

Name [required]: BCBS FEDERAL	Insurer Type [required]: PRIVATE	Long Name: BCBS FEDERAL
Street Address: PO BOX 27630	City: ALBUQUERQUE	State: NEW MEXICO
Zip Code: 87125-7630	Phone: (800) 245-1609	
Contact Person:		
Billing Office: BCBS FEDERAL	Billing Street: PO BOX 27630	Billing City: ALBUQUERQUE
Billing State: NEW MEXICO	Billing Zip Code: 87125-7630	
Status [required]: BILLABLE	Rx Billing Status: UNBILLABLE	

Discard Save

MEDICARE

MEDICARE

Administered by Federal government

Provides health insurance

- 65 years and older
- disabled people under 65
- individuals with End Stage Renal Disease (ESRD)

Stored in the Medicare Eligible file

Data stored exactly as shown on Medicare card

- Common Working File (CWF)

Patient's card should be checked at least once a year

Types of Medicare

Medicare Part A

- Hospital Insurance
  - Inpatient Care
- Patients automatically receive Part A if they have worked and payed into Medicare 10 years, “40 Qualifying Quarters” and be 65yrs or older.
- Patients can also pay a premium if they did not meet the required number of quarters.

Medicare Part B

- Medical Insurance
  - Outpatient Care
- Also covers “some” physical and occupational therapy services and “some” home health. (Must be medically necessary.)
- Requires a monthly premium, however can be payed for by State assistant programs (Medicaid).

Current rates for 2024

- Lower 48 states
  - Medicare impatient ancillary Part B $963
  - Medicare outpatient per visit rate $667
- Alaska
  - Medicare impatient ancillary Part B $1,341
  - Medicare outpatient per visit rate $961

Types of Medicare

Medicare Part D

- Prescription Drug Coverage
- Will have a separate card.
- Monthly premium.

Medicare Part C (Advantage)

- “Private Insurance”
- Still have all the Part A and B benefits with added ones. Plans MIGHT include dental, vision or prescription drugs.

Medicare Supplements

- Follows Medicare guidelines
- Will have same Part A and B benefits
- Pays for out-of-pocket costs associated with Part A and B.

Medicare Secondary Payer Questionnaire (MSP or MSPQ)

FORM ON NEXT SLIDE

MEDICARE SECONDARY PAYER QUESTIONNAIRE

PART I

Are you receiving Black Lung Benefits? ____Yes Date benefits began:_____

(BLACK LUNG (BL) IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.) ____No

1. Are the services to be paid by a government program, such as, a research grant? ____Yes **(GOVERNMENT PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.)** ____No
2. Has the Department of Veteran Affairs (DVA) authorized and agreed to pay for care at this facility?
   ____Yes **(DAV IS PRIMARY FOR THESE SERVICES.)** ____No
3. Was the illness/injury due to a work related accident/condition? ____Yes
   Date of injury/illness: _____
   Name and address of Worker's Compensation (WC) plan:
   _____
   Patient's policy/identification number: _____
   Name and address of employer: _____
   (WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK INJURIES OR ILLNESS.)
   GO TO PART III
   ____No **GO TO PART II**

PART II

1. Was the 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:
   _____
   Insurance claim number: _____
   (LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT.)
   GO TO PART III

PART III

Are you entitled to Medicare based on:

____Age **(GO TO PART IV)** ____Disability **(GO TO PART V)** ____ESRD **(GO TO PART VI)**

PART IV: AGE

1. Are you current employed? ____Yes Name and address of your employer:
   _____
   ____No Date of retired: _____
2. Is your spouse currently employed: ____Yes Name and address of your employer:
   _____
   ____No Date of retired: _____
   IF THE PATIENT ANSWERS NO TO BOTH QUESTIONS 1 & 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 a group health plan (GHP) coverage based on your own, or spouse'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.** **(THE GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.)**
   Name/address of GHP: _____
   Policy Identification No.: _____Group No.:_____
   Name of Policy Holder: _____Relationship to patient: _____
   ____No **STOP.** **(MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.)**

HRN: _____

PART V: DISABILITY

1. Are currently employed?
   ____ Yes. Name and address of your employer: _____
   ____ No. Date of retirement: _____
2. Is a family member currently employed?
   ____ Yes. Name and address of your employer: _____
   ____ No. Date of retirement: _____
   IF THE PATIENT ANSWERS "NO" TO BOTH QUESTIONS 1 & 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 a group health plan (GHP) coverage based on your own or a family member's current employment?
   ____ Yes ____ No
4. Does the employer that sponsors your GHP employ 100 or more employees?
   ____ Yes **STOP. GROUP HEALTH PLAN IS PRIMARY.**
   Name/address of GHP: _____
   Policy Identification No.: _____Group No.:_____
   Name of Policy Holder: _____Relationship to patient: _____
   ____ No **STOP.** **(MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.)**

PART IV: END STAGE RENAL DISEASE (ESRD)

1. Do you have a Group Health Plan (GHP) coverage? ____ Yes ____ No
   Name/address of GHP: _____
   Policy Identification No.: _____Group No.:_____
   Name of Policy Holder: _____Relationship to patient: _____
2. Have you received a kidney transplant?
   ____ Yes Date of transplant: _____
   ____ No
3. Have received maintenance dialysis treatments?
   ____ Yes Date dialysis began: _____
   ____ No
4. Are you within the 30 month coordination period?
   ____ Yes
   ____ No **STOP. MEDICARE IS PRIMARY.**
5. Was you initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?
   ____ Yes **STOP. THE GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**
   ____ No **STOP. INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**
6. Does the working age or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement?)
   ____ Yes **STOP. THE GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**
   ____ No **STOP. MEDICARE CONTINUES TO PAY PRIMARY.**

FAILURE TO OBTAIN THE INFORMATION LISTED IN THESE SECTIONS IS A VIOLATION OF YOUR PROVIDER AGREEMENT WITH MEDICARE, SECTION 142.3F. THE INFORMATION YOU MUST OBTAIN IS ESSENTIAL TO FILING A PROPER CLAIM WITH MEDICARE OR PRIMARY PAYER. FAILURE TO FILE A PROPER CLAIM CAN RESULT IN THE UNNECESSARY DENIAL OR DEVELOPMENT OF CLAIMS.

_____ _____

Print Beneficiary's Name **Date-of-Birth**

_____ _____

Beneficiary/Representative's Signature **Date**

Clerk's Initial: _____

DEMO,PATIENT AD

6/27/1978 (46 YRS) - FEMALE

HRN: 130562
Eligibility Status: CHS & DIRECT
PCP: NOBLE,MICHAEL MD

Last Updated: 07/02/2024 By (FRANKLIN,FAWNIA D BOM)

No Record Flags | Not Sensitive | No RHI | Active Insurance | Veteran

Profile | Insurance | Prior Auth | Benefits Cases | Appointments

Print

- Insurance Coverage
- Insurance Sequence
- MSP Surveys

MSP Surveys

Add MSP Survey

DATE SURVEY GIVEN	SIGNATURE DATE	MSP PATIENT	MEDICARE SECONDARY REASON	COMPLETED BY	
07-02-2024	07-02-2024	NO		FRANKLIN,FAWNIA D BOM	Edit
08-12-2022	08-12-2022	YES	EMPLOYER GROUP HEALTH PLAN (EGHP)	FRANKLIN,FAWNIA D BOM	Edit

MSP Questionnaire

Date Survey Given [required]

07-02-2024

PART I

1 Are you receiving Black Lung (BL) Benefits?

- [ ] Yes BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL.
- [x] No

2 Are the services to be paid by a government research program?

- [ ] Yes GOVERNMENT RESEARCH PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.
- [x] No

3 Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?

- [ ] Yes DVA IS PRIMARY FOR THESE SERVICES.
- [x] No

4 Was the illness/injury due to a work-related accident/condition?

- [ ] Yes WC IS PRIMARY PAYER ONLY FOR CLAIMS FOR WORK-RELATED INJURIES OR ILLNESS, GO TO PART III.
- [x] No GO TO PART II

PART II

1 Was illness/injury due to a non-work-related accident?

- [ ] Yes
- [x] No GO TO PART III

PART III

1 Are you entitled to Medicare based on:

- [x] Age. Go to PART IV.
- [ ] Disability. Go to PART V.
- [ ] End-Stage Renal Disease (ESRD). Go to PART VI.

Please note that both "Age" and "ESRD" OR "Disability" and "ESRD" may be selected simultaneously. An individual cannot be entitled to Medicare based on "Age" and "Disability" simultaneously. Please complete ALL "PARTS" associated with the patient's selections

PART IV - AGE

1 Are you currently employed?

- [ ] Yes
- [x] No

Date of Retirement

12-31-2023

2 Do you have a spouse who is currently employed?

- [ ] Yes
- [x] 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 II. DO NOT PROCEED FURTHER.

MSP Patient [required]

Yes | No

Signature Date [required] 07-02-2024

Completed By [required] FRANKLIN,FAWNIA D BOM

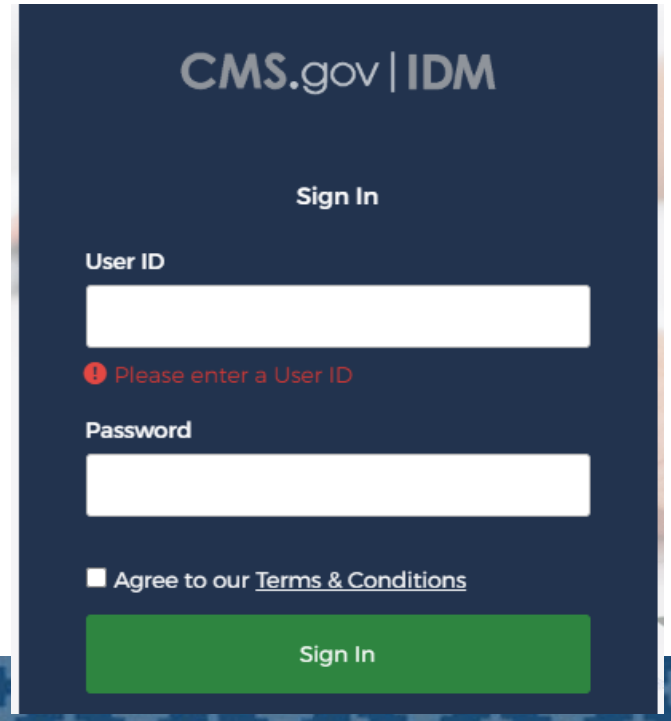
Discard Save

Verifying Medicare

First, you must have a login for NOVITASPHERE

https://idm.cms.gov/

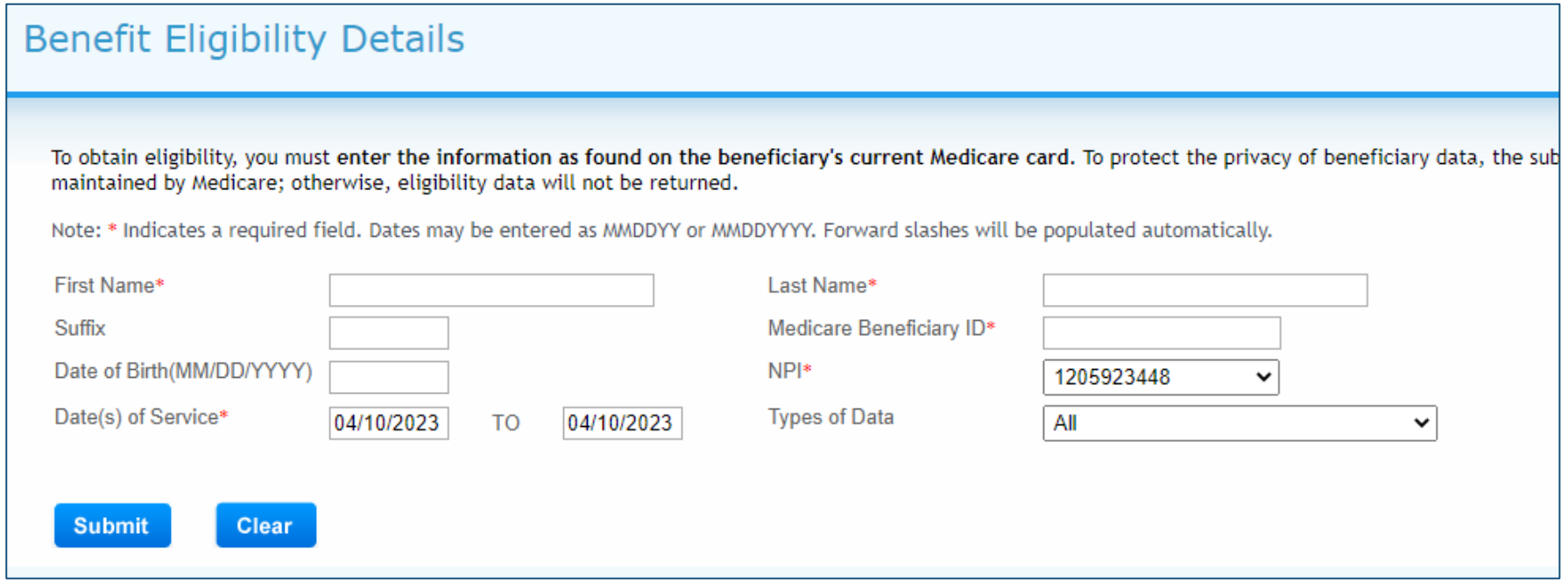
Enter your login information and go through the steps to verify your identity



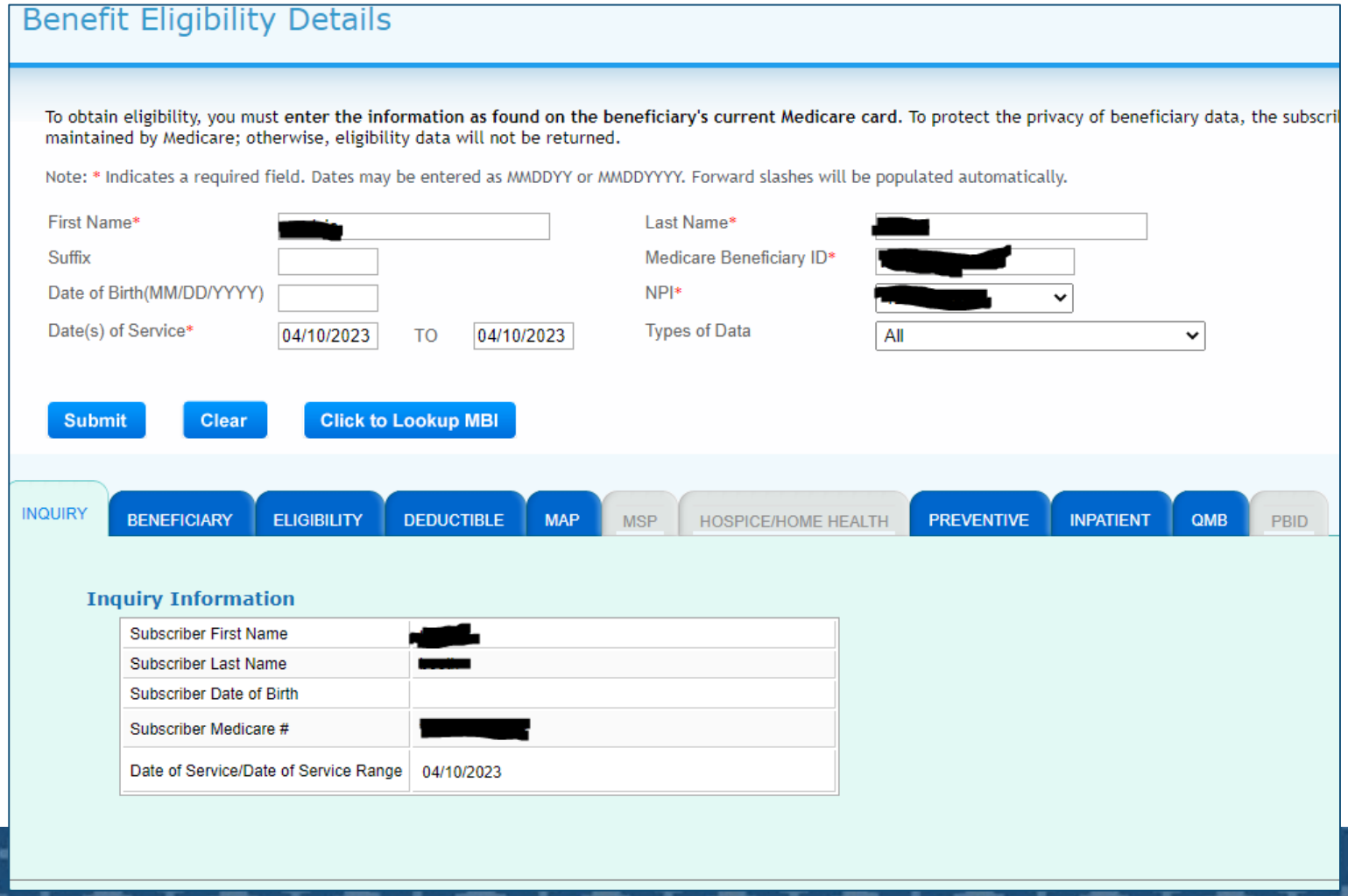
Verifying Medicare

- Once you signed in, click on ELIGIBILITY

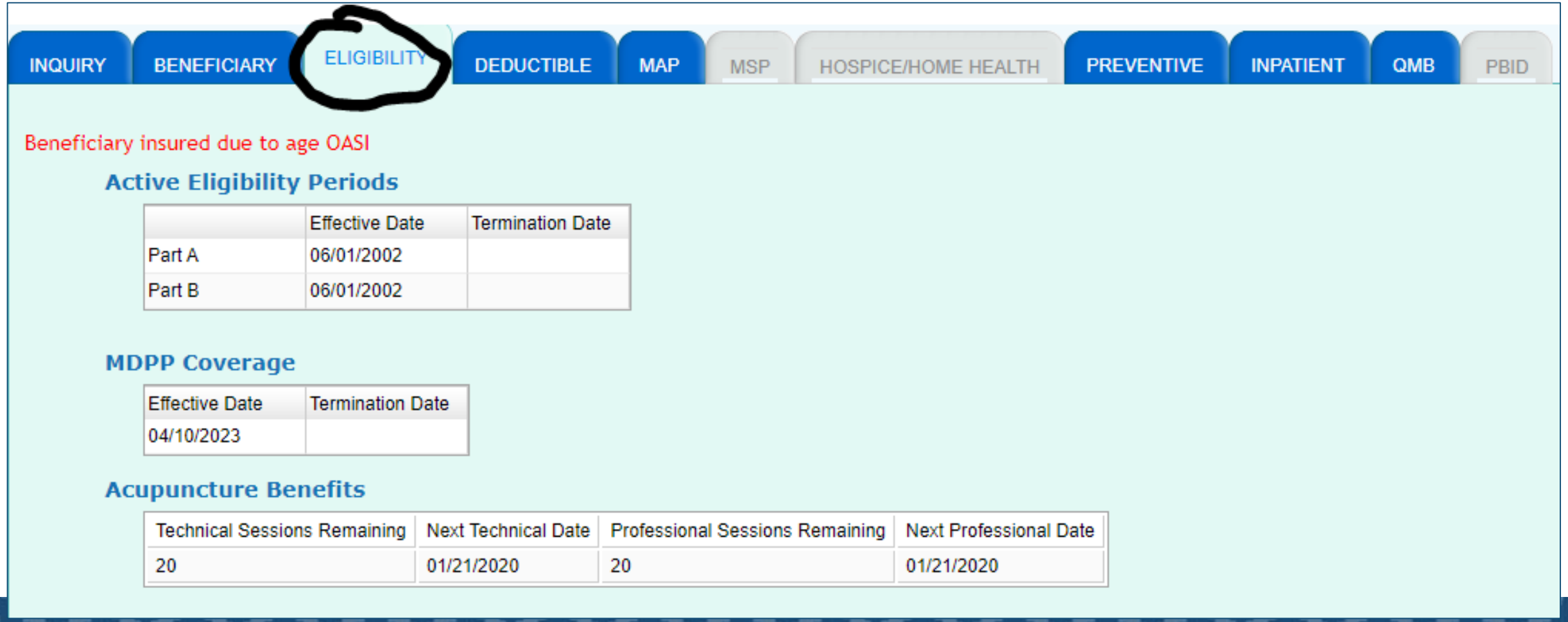
- …and enter your patient information on the form



Verifying Medicare

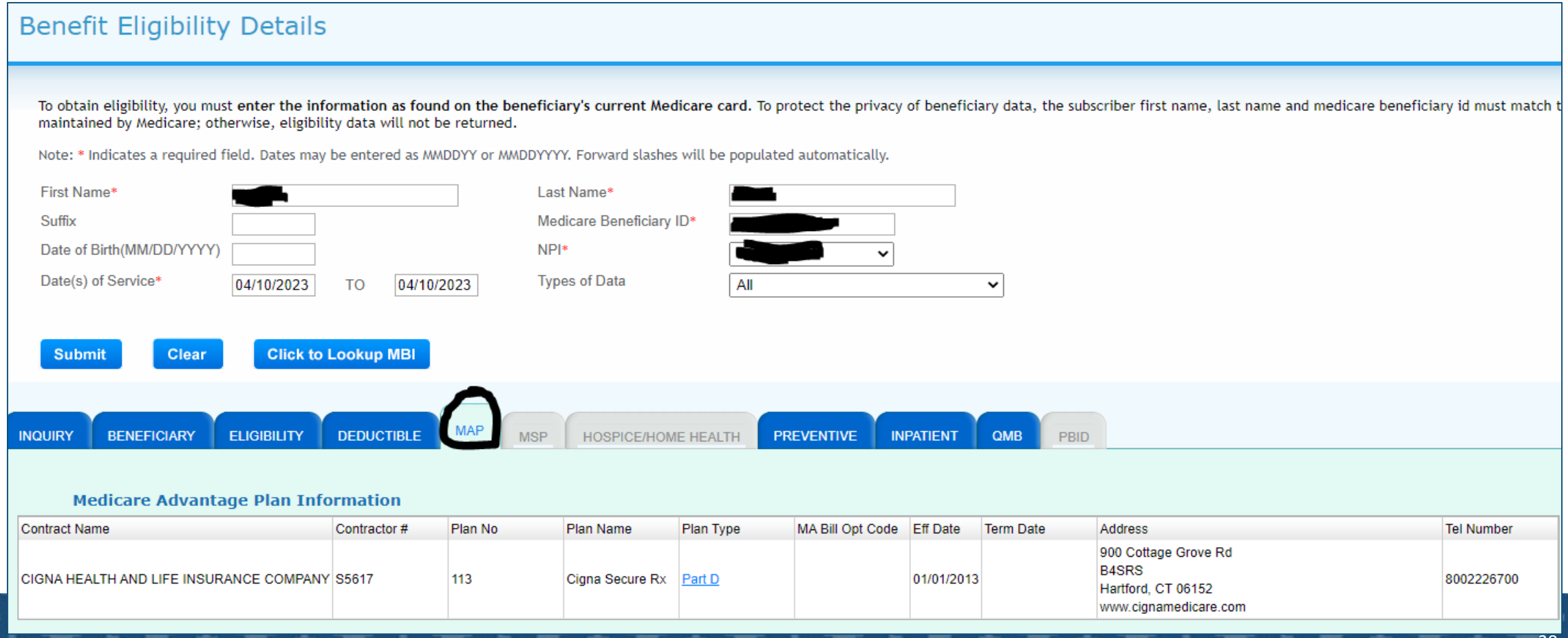


Verifying Medicare



Verifying Medicare

Patient with MCR Part D



Verifying Medicare

Patient with MCR Part C

Medicare Advantage Plan Information

Contract Name	Contractor #	Plan No	Plan Name	Plan Type	MA Bill Opt Code	Eff Date	Term Date	A
CARE IMPROVEMENT PLUS SOUTH CENTRAL INSURANCE CO.	H5322	031	UnitedHealthcare Dual Complete LP	Part D		07/01/2019		2 L U
CARE IMPROVEMENT PLUS SOUTH CENTRAL INSURANCE CO.	H5322	031	UnitedHealthcare Dual Complete LP	HN	MA Bill Option Code - C	07/01/2019		2 L U

Medicare

Medicare Name [required]	Medicare MBI Number [required]	Date Of Birth [required]	Medicare Release Date [required]
DEMO,PATIENT H	6T21V40RA64	01-02-1930	01-02-1996

Medicare HICN Number	Suffix	Primary Care Provider	QMB/SLMB
000000099	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	
01-02-1996		A	Edit | Remove
01-02-1996		B	Edit | Remove

Discard Save

MEDICAID

Medicaid

Patient Registration needs to know:

- **Medicaid Expansion**
- **Managed Care**
- **Traditional**

May be itemized or billed at the All-Inclusive Rate

Reimbursed at the All-inclusive rate

Current rates for 2024:

- Outpatient: Lower 48 States= $719.00; Alaska= $1,060.00
- Inpatient Hospital: Lower 48 States= $5,083.00; Alaska= $4,326.00

Medicaid Supplemental

Income Based

Eligible Groups: 65yrs and older; disabled; ESRD

Helps pay for Cost Sharing expenses (deductibles and co-insurance)

Three Qualifying Programs

- Qualified Medicare Beneficiary (QMB)
  SoonerCare Supplemental may assist with payments for Medicare Part A and Part B premiums, deductibles and coinsurance QMB is entitled to Medicare Part A and has qualifying low income and limited resources.
- Specified Low-Income Medicare Beneficiary (SLMB)
  SoonerCare Supplemental may assist with payments for Medicare Part B premiums if SLMB is receiving Medicare Part A and has qualifying low income and limited resources.
- Qualifying Individuals (QI-1)
  SoonerCare Supplemental may assist with payments for Medicare Part B premiums if the individual is entitled to Medicare Part A, has qualifying low income and limited resources and is not otherwise eligible for full-benefit SoonerCare.

Medicaid

Medicaid Name [required]	Medicaid Number [required]	Date Of Birth [required]	Relationship
DEMO,PATIENT AD	123456789	06-27-1978	Self

Plan Name	State [required]
NEW MEXICO MEDICAID	NEW MEXICO

Group Name/Number	Primary Care Provider	Rate Code
BCBSNM N72100 - N72100		

Card Copy on File

Eligibilities

Add

START DATE	END DATE	COVERAGE TYPE	
09-18-2023		100	Edit | Remove

Discard Save

PRIVATE INSURANCE

Private Insurance

Each payer will be different when it comes to what is covered under the medical plan.

- Remember, the plans for each employer differs as well.

Not all PI's will cover dental, pharmacy, optometry or behavioral health.

Most medical plans cover medical, pharmacy and behavioral health.

Private - VA MEDICAL BENEFIT (VMBP)

Registered

Name as Stated on Policy [required]: DEMO,PATIENT AD

Policy Number or SSN [required]: 987654321

Effective Date [required]: 01-01-2024

Expiration Date: __-__-____

Policy Holder Sex [required]: FEMALE

Date Of Birth [required]: 06-27-1978

Primary Care Provider:

CD Name:

Holder's Employer Info

Status: FULL-TIME

Employer: CITY OF GALLUP

Holder's Address

Street [required]: 516 E NIZHONI BLVD

City [required]: GALLUP

State [required]: NEW MEXICO

Zip Code [required]: 87301

Phone Number: 505-722-1000

Insurer Information

Group Name/Number: VMBP - IHS

Coverage Type: PRIORITY GRP 2

Card Copy on File:

Policy Members

Add

MEMBER NAME	START DATE	END DATE	RELATIONSHIP	
DEMO,PATIENT AD	01-01-2024		SELF	Edit | Remove

Discard | Save

Policy Member

Policy Member [required]

DEMO,PATIENT AD

Relationship [required]

SELF

Person Code

18

Start Date [required]

01-01-2024

End Date

__-__-____

Member Number

987654321

Cancel OK

PRIOR AUTH

Prior Authorization

Encounter Date [required]

__-__-____

Authorization Type [required]

Please Select

Please Select
INPATIENT
OUTPATIENT

Insurer

Search

Authorization Status

PENDING

Authorization Date

__-__-____

Authorized Visits

Encounter Notes

Authorizing Contact

Contact Date

__-__-____

Contact Person

Contact Phone

Contact Fax

Contact Email

Notes

Discard Save

Prior Authorization

Encounter Date [required]
__-__-____

Authorization Type [required]
Please Select

Insurer
Search

Authorization Status
PENDING

Authorization Number

Authorization Date
__-__-____

Authorized Visits

Encounter Notes

Authorizing Contact

Contact Date
__-__-____

Contact Person

Contact Phone

Contact Fax

Contact Email

Notes

Discard Save

Prior Authorization

Encounter Date [required]: 06-11-2024

Authorization Type [required]: INPATIENT

Insurer: BCBS FEDERAL

Authorization Status: FOLLOW UP NEEDED

Authorization Number: PENDING

Authorization Date: __-__-____

Authorized Days:

Max Dollar Amount:

Actual Admission Date: __-__-____

Encounter Notes:

PENDING CLINICAL REVIEW.

Authorizing Contact

Add

CONTACT DATE	CONTACT PERSON	CONTACT PHONE	CONTACT FAX	CONTACT EMAIL	
06-12-2024	LASTNAME,FIRST	555-555-0000	555-555-0001	FIRSTLASTNAME@PRIORAUTH.COM	Edit | Remove

Additional Days

Add

OBTAINED ON	CONTACT PERSON	REFERENCE NUMBER	ADDITIONAL DAYS AUTHORIZED
No data			

Discard Save

DEMO,PATIENT AD

6/27/1978 (45 YRS) - FEMALE

HRN: 130562
Eligibility Status: CHS & DIRECT
PCP: NOBLE,MICHAEL MD

Last Updated: 06/12/2024 By (FRANKLIN,FAWNIA D BOM)

No Record Flags | Not Sensitive | No RHI | Active Insurance | Veteran

Profile | Insurance | Prior Auth | Benefits Cases | Appointments

Print

STATUS
- All
- Approved
- Pending
- Denied
- Refused
- Re Submitted
- Follow up needed
- Authorization not needed
- Entered in error

Prior Authorizations

Add Prior Authorization

ENCOUNTER DATE	TYPE	INSURER	AUTHORIZATION DATE	AUTHORIZATION NO	STATUS	
06-11-2024	INPATIENT	BCBS FEDERAL		PENDING	FOLLOW UP NEEDED	Edit | Delete

Showing 1 to 1 of 1 results

‹ 1 ›

WORKER'S COMP

Workmen's Comp - CRAWFORD & COMPANY

Date of WC Injury [required]: 07-01-2024

Type of Accident: FALL

Description of Injury: SPRAINED RIGHT ANKLE

Employer Data

Patient's Employer:

Attorney Data

Name Of Patient's Attorney:

Insurance Coverage

Workman's Comp Entity [required]: CRAWFORD & COMPANY

Group Name/Number: Search

Effective Date [required]: 07-01-2024

Expiration Date: __-__-____

Claim Information

Claim Filed: ☑

Claim Status: PENDING

Claim Number [required]: PENDING

Date Last Worked: 07-01-2024

Disability Start Date: __-__-____

Disability End Date: __-__-____

Date Authorized Return To Work: __-__-____

Contact Info:

Notes: CLAIMS ADJUST NAME AND PHONE/FAX NUMBER.

Discard | Save

Questions?

References

CMS Medicare MSP Manual

SoonerCare Supplemental (oklahoma.gov)


INDIAN HEALTH SERVICE
PHS · 1955 ·