



Provider Web Portal Quick Guide - Verifying Member Eligibility (including Managed Care Assignment Details and Benefit Plan Information) and Co-Pay

This Quick Guide provides step-by-step instructions on how to verify member eligibility and co-pay details.

Refer to the chart on page 8 of this guide for more information on benefit plans and billing instructions.

1. Log in to the Provider Web Portal.

2. Click the Eligibility tab.

The screenshot shows the Health First Colorado Provider Web Portal interface. At the top left is the Colorado HCPF logo and the text "COLORADO Department of Health Care Policy & Financing". At the top right is the "Health First COLORADO" logo with the tagline "Colorado's Medicaid Program" and links for "Contact Us" and "Logout". Below the header is a navigation menu with tabs for "Home", "Eligibility", "Claims", "Care Management", and "Resources". The "Eligibility" tab is highlighted with a blue box. Below the navigation menu, the page displays "Home" on the left and "Monday 02/27/2017 08:49 PM MST" on the right. A large blue box contains a form with fields for "Provider Name", "Provider ID", "Location", and "Taxonomy". Below this, a green "User Details" sidebar shows a welcome message "Welcome CaseManager1" and links for "My Profile" and "Manage Accounts". A central banner says "Welcome Health Care Professional!" with a photo of a doctor and patient. On the right, there are "Contact Us" and "Notify Me" buttons.

3. Click the Eligibility Verification link.

The screenshot shows the top navigation bar with 'Home', 'Eligibility', 'Claims', 'Care Management', and 'Resources'. Below the navigation bar is a green header for 'Eligibility Verification'. The main content area shows a search form with fields for 'Provider Name', 'Provider ID Location', and 'Taxonomy'. A yellow box highlights the 'Eligibility' button, and a red box highlights the 'Eligibility Verification' link below it. The date and time 'Monday 02/27/2017 08:50 PM MST' are displayed in the top right.

4. Enter search criteria, then click "Submit."

The screenshot shows the 'Eligibility Verification Request' form. The 'Member ID' field is highlighted with a yellow box and contains the value 'A123456'. Other fields include 'Last Name', 'First Name', 'SSN', 'Birth Date', 'Effective From' (03/03/2017), 'Effective To', and 'Verification for Newborn?'. Below the form is a 'Service Type Code' section with a 'Search By' dropdown and a 'Service Type Code' input field. At the bottom, the 'Submit' button is highlighted with a yellow box, and the 'Reset' button is highlighted with a green box. The date and time 'Friday 03/03/2017 11:27 AM MST' are displayed in the top right.

5. Review the search results.

Member ID	Birth Date	Gender	Female
Coverage	Effective Date	End Date	
Medicaid State Plan	08/01/2016	12/31/2299	
Behavioral Health Benefits	08/01/2016	12/31/2299	
HCBS Elderly, Blind, & Disabled Waiver	08/01/2016	12/31/2299	
Qualified Medicare Beneficiary	09/01/2014	12/31/2299	
Other Insurance Detail Information			

6. Click "Expand All" to view Benefit Details, Coverage, Co-payments and Managed Care Assignment Details.

The screenshot below shows Coverage Details, Benefit Details and Managed Care Assignment Details.

Coverage Details
[Back to Eligibility Verification](#) ?

Coverage Details for Member ID [REDACTED] - [REDACTED] from 01/01/2014 to 12/31/2299
 Eligibility Verification Response Guarantee Number [REDACTED]

Expand All | [Collapse All](#)

Benefit Details
▾

Coverage	Description	Effective Date	End Date
TXIX	Medicaid State Plan - BJ	04/30/2018	04/30/2018
BHO+B	Behavioral Health Benefits - BJ	04/30/2018	04/30/2018

Coverage	Copayments	Amount
TXIX	Medical Care	\$0.00
TXIX	Dental Care	\$0.00
TXIX	Hospital	\$0.00
TXIX	Hospital - Inpatient	\$0.00
TXIX	Hospital - Outpatient	\$0.00
TXIX	Emergency Services	\$0.00
TXIX	Brand Name Prescription Drug	\$0.00
TXIX	Generic Prescription Drug	\$0.00
TXIX	Professional (Physician) Visit - Office	\$0.00
TXIX	Vision (Optometry)	\$0.00
TXIX	Mental Health	\$0.00
TXIX	Urgent Care	\$0.00
BHO+B	Hospital	\$0.00
BHO+B	Hospital - Inpatient	\$0.00
BHO+B	Hospital - Outpatient	\$0.00
BHO+B	Emergency Services	\$0.00
BHO+B	Professional (Physician) Visit - Office	\$0.00
BHO+B	Mental Health	\$0.00

Managed Care Assignment Details
▾

Current MCO	Benefit Plan
ADAMS COUNTY SCHOOL DISTRICT 5	Primary Care Medical Provider
ROCKY MOUNTAIN HEALTH PLANS	Regional Accountable Entity
DENTAQUEST USA INSURANCE CO IN	Administrative Service Organization - Dental

7. Verify member co-pay requirements by referring to the "Amount" column under the Benefit Details section.

Benefit Details			
Coverage	Description	Effective Date	End Date
TXIX	Medicaid State Plan - HD	04/30/2018	04/30/2018
BHO+B	Behavioral Health Benefits - HD	04/30/2018	04/30/2018
ABP	Alternative Benefit Plan - HD	04/30/2018	04/30/2018
Coverage	Copayments	Amount	
TXIX	Medical Care	\$0.00	
TXIX	Dental Care	\$0.00	
TXIX	Hospital	\$0.00	
TXIX	Hospital - Inpatient	\$0.00	
TXIX	Hospital - Outpatient	\$0.00	
TXIX	Emergency Services	\$0.00	
TXIX	Brand Name Prescription Drug	\$0.00	
TXIX	Generic Prescription Drug	\$0.00	
TXIX	Professional (Physician) Visit - Office	\$0.00	

The Department’s co-pay policy has recently been updated. Some members may not be required to pay a co-pay for every visit, so it is important that providers check the co-pay amount every time they see a Health First Colorado member. If a member has already reached their 5% co-pay maximum for a given month, it will say “Member co-pay is exempt.”

Scroll to the bottom of the page to see Managed Care Assignment Details.

8. If applicable, check the member’s available units of physical/occupational therapy (PT/OT) services under the Limit Details section.

Benefit Details			
Coverage	Description	Effective Date	End Date
QMB	Qualified Medicare Beneficiary - F4	08/16/2018	08/16/2018
EBD	HCBS Elderly, Blind, & Disabled Waiver - M8	08/16/2018	08/16/2018
TXIX	Medicaid State Plan - M8	08/16/2018	08/16/2018
BHO+B	Behavioral Health Benefits - M8	08/16/2018	08/16/2018
Coverage	Copayments	Amount	
QMB	Medical Care	\$0.00	
QMB	Chiropractic	\$0.00	
QMB	Dental Care	\$0.00	
Limit Details			
		Limit	Used
Individual	5500 PT & OT SVC LIMITS = 48/YR	48	6
	5640 HOME HEALTH EVALUATION FOR MODIFICATION LIMIT	2	4
Managed Care Assignment Details			
Current MCO		Benefit Plan	
DENTAQUEST USA INSURANCE CO IN		Administrative Service Organization - Dental	

This remaining benefit amount is calculated by counting all the paid units of service for PT/OT a member has incurred in the previous rolling 365 days. Once the soft limit of 48 units has been reached, an approved Prior Authorization Request (PAR) is required to exceed it.

The counting function will calculate PT/OT units regardless of whether they were paid with a PAR on file. This means that after a PAR for PT/OT is exhausted members will not automatically have another 48 units of PT/OT available without a PAR. A full 365 days must elapse before the member has another 48 units of PT/OT available without requiring a PAR.

Refer to the Benefit Limitation Frequently Asked Questions, located on the [Outpatient PT/OT Benefits web page](#), for more information.

**9. Scroll to the Managed Care Assignment Details section, then click the [+]
sign.**

Click the plus [+] sign next to Managed Care Assignment Details.

TXIX	Mental Health	\$0.00
TXIX	Urgent Care	\$0.00
Managed Care Assignment Details		+

The program name under which the member is eligible will display under the Current MCO column. The benefit plan type for that particular program will display in the same row under the Benefit Plan column.

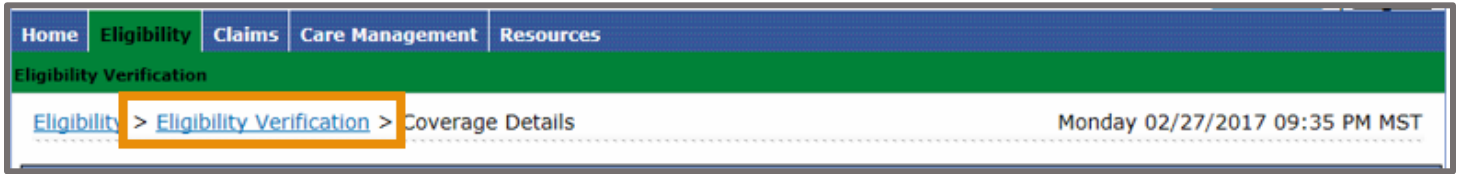
Managed Care Assignment Details	
Current MCO	Benefit Plan
ROCKY MOUNTAIN PLANNED PARENTH	Primary Care Medical Provider
COLORADO ACCESS	Regional Accountable Entity
DENTAQUEST USA INSURANCE CO IN	Administrative Service Organization - Dental

See the table below for a complete list of all possible benefit plans along with billing instructions and co-pay notes.

Benefit plans for which providers should bill DXC directly are marked in **green** below. Benefit plans for which providers should bill the listed Managed Care Organization are marked in **red** below.

MC Benefit Plan	Billing	Co-pay
<u>Denver Health Medicaid Choice (PIHP)</u>	Providers should bill Denver Health directly, not DXC for medical claims. Mental health is billed to the RAE. Span must show "Active."	Most services, such as office visits, medications and hospital stays have co-pays. Services for pregnant women, children 18 and under, American Indians and Alaska Natives do not require a co-pay.
<u>Denver Health and Hospital Authority - Primary Care Medical Provider</u>	Providers should not bill the PCMP and instead should bill DXC directly for medical claims. Mental health is billed to the RAE.	Not applicable
Rocky Mountain Health Plans	Providers should bill the RAE for mental health services (behavioral therapy is an exception). Medical claims should be billed to DXC directly.	
<u>Rocky Mountain Health Plans Prime</u>	Providers should bill Rocky Mountain Health Plans Prime directly, not DXC. Mental health should be billed to the RAE.	Contact Rocky Mountain Health Plans Prime for co-pay details.
<u>Accountable Care Collaborative</u>	Providers should not bill the ACC, PCMP or RCCO and instead should bill DXC Technology (DXC) directly (unless the services are for mental health). Note: ACC will only appear for dates of service prior to 7/1/18.	Not applicable
Administrative Service Organization - Dental	Providers should bill DentaQuest directly, not DXC.	Contact DentaQuest for co-pay details.
<u>Child Health Plan Plus</u> or <u>Child Health Plan Plus - Dental</u> or <u>State Managed Care Network - CHP+</u>	Providers should bill Child Health Plan Plus (CHP+) directly, not DXC.	Some CHP+ clients may also have to pay co-pays to their health care provider at the time of service. There are no co-pays for preventative care, such as prenatal care and check-ups. Other services may require co-pays based on member income. Native Americans and Alaskan Natives do not have to pay co-pays.
<u>Primary Care Medical Provider</u>	Providers should not bill the RAE or PCMP and instead should bill DXC directly for medical claims. Mental health should be billed to the RAE.	Not applicable
<u>Program For All-Inclusive Care For The Elderly</u>	Providers should bill the Program of All-Inclusive Care for the Elderly (PACE) directly, not DXC.	There are no co-payments or out-of-pocket expenses for services covered under this program.
<u>Regional Accountable Entity</u> <i>[formerly known as Behavioral Health Organizations (BHOs) and Regional Care Collaborative Organizations (RCCOs)]</i>	Providers should bill the RAE for mental health services (behavioral therapy is an exception). Medical claims should be billed to DXC directly, unless they have Denver Health PHIP or Rocky Mountain Prime.	There are no co-pays for Health First Colorado behavioral health services. However, if the member has other insurance, they must use that insurance first before using Health First Colorado benefits.

10. To see Third Party Liability (TPL) coverage (including Medicare), return to the Eligibility Verification page.



11. Scroll to bottom of page and click "Other Insurance Detail Information."

Eligibility Verification Information for				from 02/27/2017 to 02/27/2017	
Member ID	Birth Date	Gender	Female		
Coverage	Effective Date	End Date			
Medicaid State Plan	08/01/2016	12/31/2299			
Behavioral Health Benefits	08/01/2016	12/31/2299			
HCBS Elderly, Blind, & Disabled Waiver	08/01/2016	12/31/2299			
Qualified Medicare Beneficiary	09/01/2014	12/31/2299			
Other Insurance Detail Information					

If Qualified Medicare Beneficiary (QMB) is listed under the Coverage column, this means the member has Medicare coverage.

If a member has QMB coverage but does not have Medicaid State Plan (TXIX) coverage, Health First Colorado will not provide payment unless Medicare pays first.

If a member has QMB and Medicaid State Plan (TXIX) coverage, then Health First Colorado is the secondary payor.

This is where other insurance coverage (including Medicare coverage) is displayed:

Other Insurance Information for Member ID								Back to Eligibility Verification	
* Indicates a required field.									
Click '+' to view details in a row. Click '-' to collapse the row.									
Carrier Name (Carrier ID)	Policy ID	Group ID	Policy Holder	Policy Type	Coverage Type	Effective From	Effective To		
Medicare A (1)	12345678A					10/01/2010	12/31/2299		
Medicare B (2)	12345678A					10/01/2010	12/31/2299		
Other Insurance Carrier Information									
Carrier 2 - Medicare B					Group ID _				
Policy ID 12345678A									
Policy Type _									
Coverage Type _									
Effective From 10/01/2010					Effective To 12/31/2299				
Other Policy Holder Information									
Relationship Self									
Save		Reset							

12. Add additional TPL information as needed.

Refer to the [Updating Additional TPL Information Provider Web Portal Quick Guide](#) for step-by-step instructions on how to add TPL information for a member with TPL coverage that isn't already listed.

Need More Help?

Please visit the [Quick Guides and Webinars](#) web page to find all the Provider Web Portal Quick Guides:

Aid Code and Benefit Plan Acronyms
Are You Billing from the Correct Account?

Copy, Adjust, or Void a Claim
Delegates

Delegate Access Definitions
Entering NDC Information on a Claim
Provider Maintenance
Provider Maintenance – License Update
Pulling Your 835 - Linking to your own TPID
Pulling Your Remittance Advice (RA)

Reading Your Remittance Advice (RA)

- Internal Control Number (ICN) Information Sheet
- Region Code Information Sheet

Submitting a Claim with Other Insurance or Medicare Crossover Information

Updating Additional TPL Information

Updating Your EFT

Updating Your ERA

Verifying Member Eligibility and Co-Pay

Viewing Prior Authorizations in the Portal

Web Portal Registration

Provider Web Portal – Frequently Asked Questions (FAQs)

Please visit the [Provider FAQ Central](#) web page and look under the Billing and Web Portal headings to see Provider Web Portal FAQs.

Provider Web Portal – Recorded Webinars

Click the links below to access the recorded webinars:

- [Session #1](#) Access the new Portal, Portal Registration, Log in, My Profile, Manage Accounts (including delegates)
- [Session #2](#) Provider Maintenance (including updates and affiliations), EFT/ERA Enrollment, Disenrollment
- [Session #3](#) Member Information and Eligibility Verification
- [Session #4](#) Remittance Advice (RA), Search Payment History, Search for Accounts Receivable Records, Make a Payment
- [Session #5](#) Notify Me, Alerts, Secure Correspondence
- [Session #6](#) Files Exchange, Resources
- [Session #7](#) Search & Submit CMS 1500, UB-04, Emergency Dental Claims, Prior Authorizations (Nursing Facility PETI PARs only)
- [Bridge](#) Bridge training for Community Centered Boards (CCBs) only