COLORADO
Department of Health Care Policy & Financing

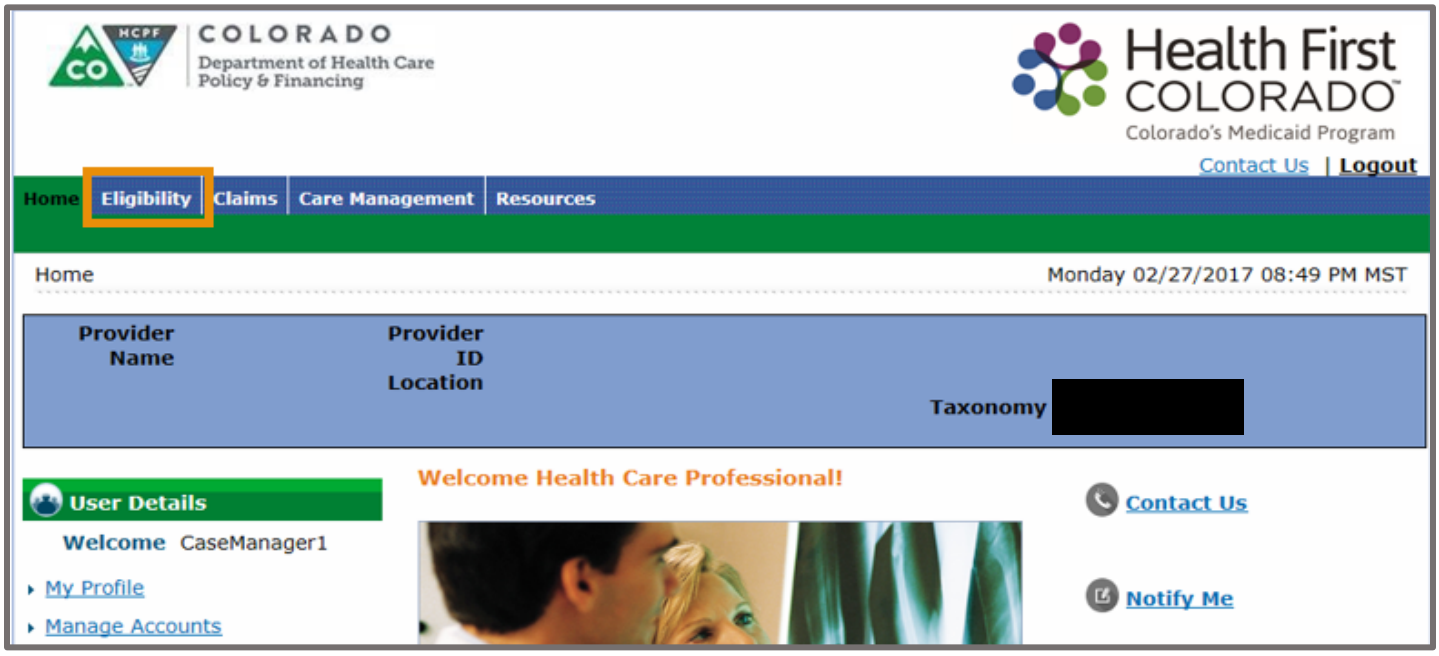
Provider Web Portal Quick Guide - Verifying Member Eligibility (including Managed Care Assignment Details and Benefit Plan Information) and Co-Pay

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

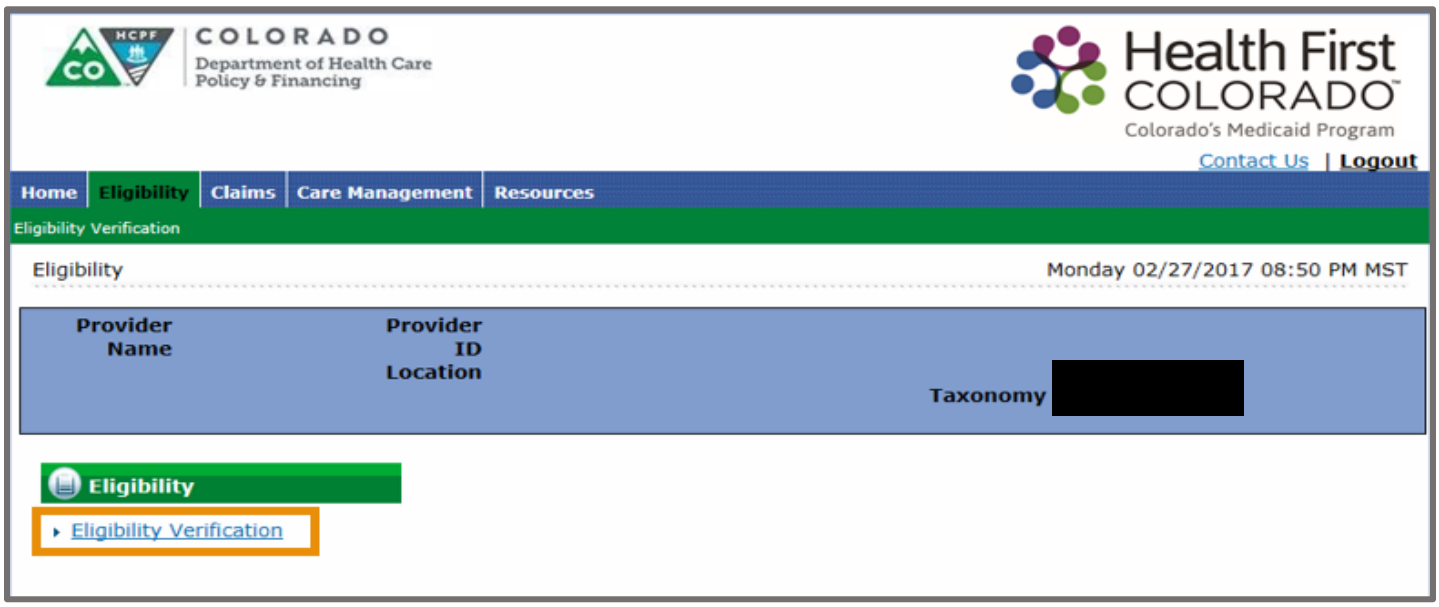
Refer to the chart on page 8 of this guide for more information on benefit plans and billing instructions.

1. Log in to the Provider Web Portal.

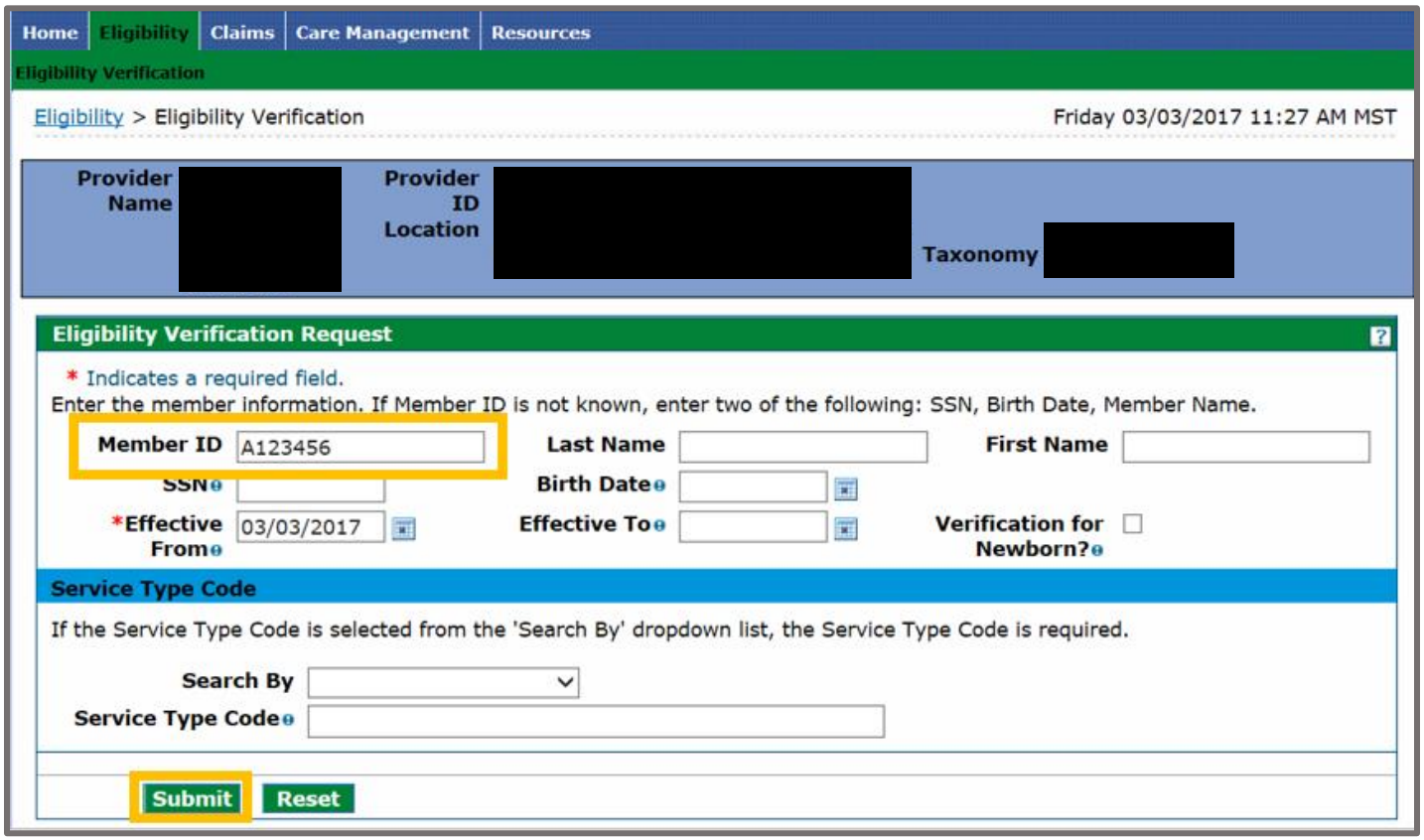
2. Click the Eligibility tab.



3. Click the Eligibility Verification link.



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



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

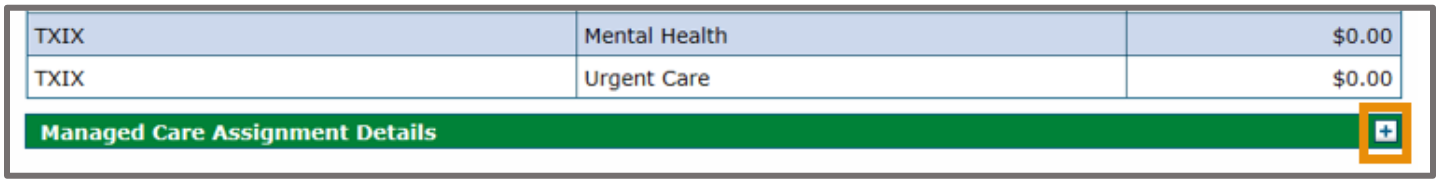
This remaining benefit amount is calculated by counting all the paid units of service for PT/OT a member has incurred in the previous rolling 365 days. Once the soft limit of 48 units has been reached, an approved Prior Authorization Request (PAR) is required to exceed it.

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.

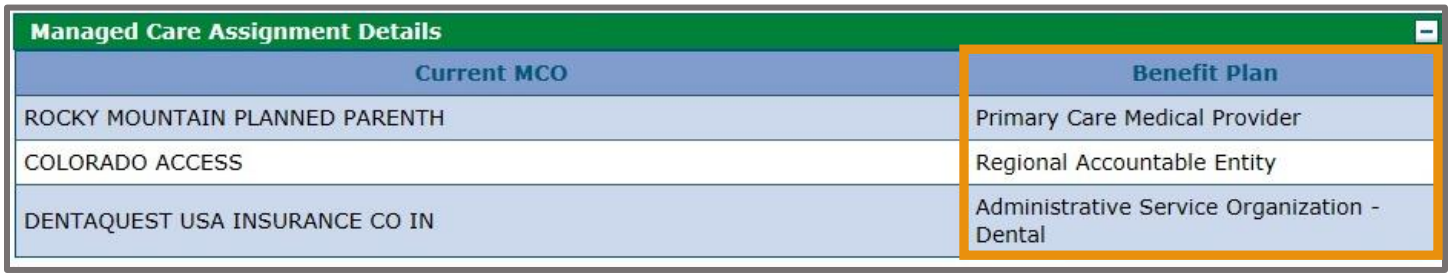
Click the plus [+] sign next to Managed Care Assignment Details.



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

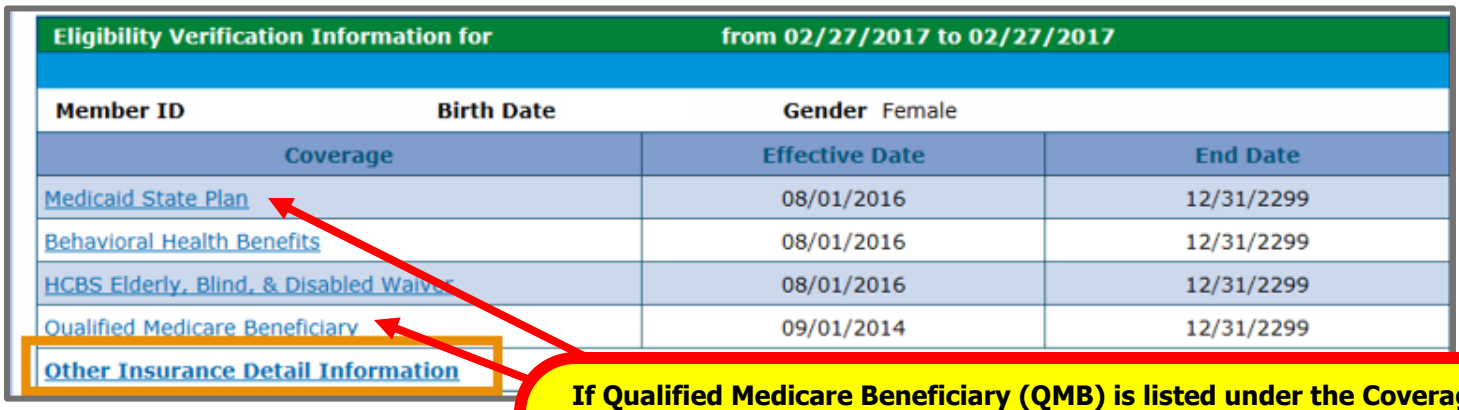
See the table below for a complete list of all possible benefit plans along with billing instructions and co-pay notes.

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
Denver Health Medicaid Choice (PIHP)	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.
Denver Health and Hospital Authority - Primary Care Medical Provider	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.	
Rocky Mountain Health Plans Prime	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.
Accountable Care Collaborative	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.
Child Health Plan *Plus* or **Child Health Plan *Plus* - Dental** or **State Managed Care Network - CHP+**	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.
Primary Care Medical Provider	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
Program For All-Inclusive Care For The Elderly	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.
Regional Accountable Entity *[formerly known as Behavioral Health Organizations (BHOs) and Regional Care Collaborative Organizations (RCCOs)]*	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."

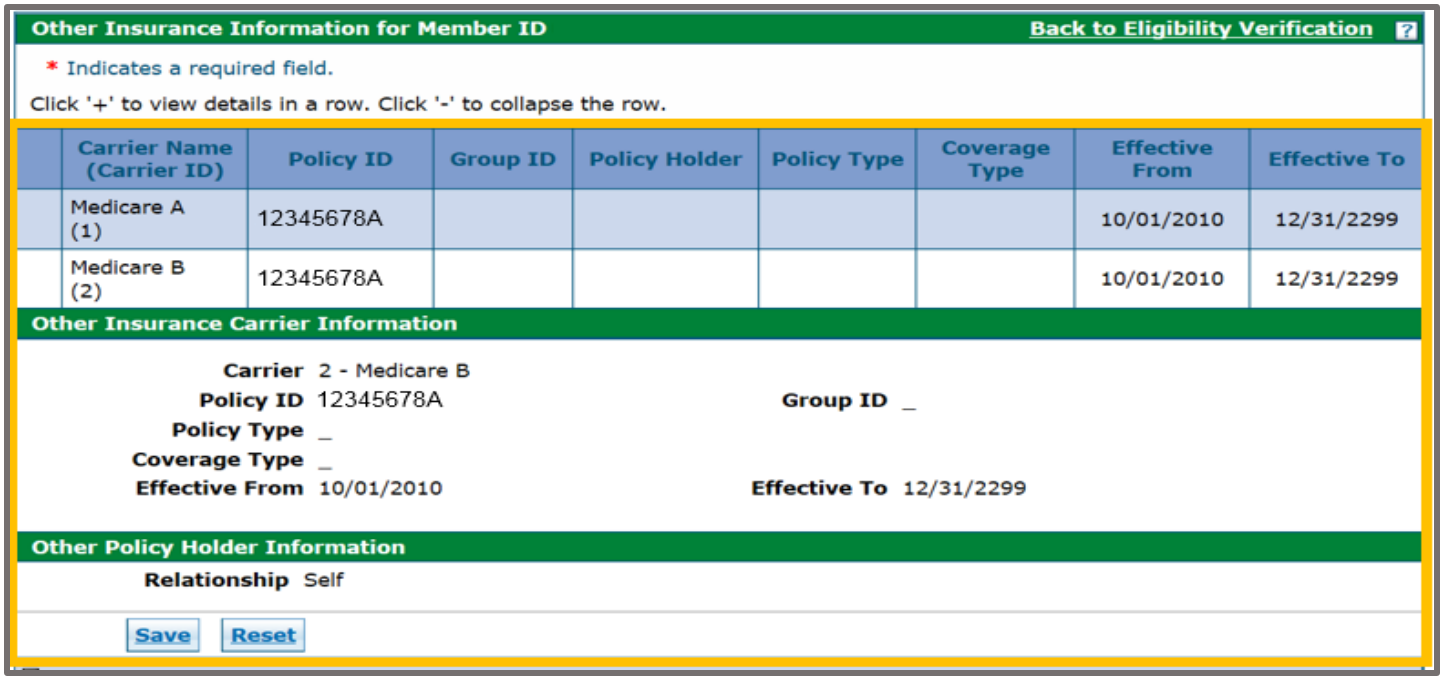


If Qualified Medicare Beneficiary (QMB) is listed under the Coverage column, this means the member has Medicare coverage.

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:



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