

SECTION 5

MEMBER ELIGIBILITY AND BENEFITS DETERMINATION

5 INTRODUCTION

This section describes the requirements for verifying member eligibility and Kaiser Permanente benefit coverage.

Providers are required to verify eligibility each time a member presents themselves for services so that services are only provided to someone who is eligible for covered services and so that they can be compensated by Kaiser Permanente for services provided to our members. **Members are issued identification cards, but the card alone is not sufficient verification of eligibility.**

- Providers are also responsible for confirming that services provided to a member are covered benefits.
- Both requirements and verification tools are described in more detail in this section.
- For specific questions regarding eligibility or a member's benefit plan and coverage for services, please visit the Affiliate Link site:

Affiliate Link Sites:

[Online Affiliate | Community Provider Portal | Kaiser Permanente](#)

Note: Each region operates separately.

Affiliate Links	
region	email
Northern California (NCAL)	KP-NCAL-OnlineAffiliate@kp.org
Southern California (SCAL)	KP-SCAL-OnlineAffiliate@kp.org
Colorado	KP-CO-OnlineAffiliate@kp.org
Georgia	KP-GA-OnlineAffiliate@kp.org
Hawaii	KP-HI-OnlineAffiliate@kp.org
Mid-Atlantic States	KP-MAS-OnlineAffiliate@kp.org
Northwest	NW-Provider-Relations@kp.org
Washington	Not participating; but they can be reached at https://wa-provider.kaiserpermanente.org/provider-support/provider-services

5.1 KAISER PERMANENTE MEMBERSHIP

MEMBERSHIP TYPE	MEMBERSHIP DEFINED	COVERED BENEFITS DEFINED BY:
Commercial	<p>Members* who purchase Health Plan coverage on an individual basis (other than Medicare and Medicaid)</p> <p>Members who are covered as part of an employer group and are not Medicare-eligible or Medicaid-eligible</p>	<p>Membership Agreement/ Evidence of Coverage</p> <p>Membership Agreement</p>
Medicare Advantage (formerly Medicare + Choice) (Senior Advantage)	<p>Individual Medicare beneficiaries who have assigned their Medicare benefits to Kaiser Permanente by enrolling in the Kaiser Permanente Senior Advantage Program</p> <p>Employer group retirees or otherwise Medicare-eligible employees who are also Medicare beneficiaries and have assigned their Medicare benefits to Kaiser Permanente by enrolling the Kaiser Permanente Senior Advantage Program</p>	<p>Medicare, with additional benefits provided by Kaiser Permanente Medicare and Membership Agreement</p>
Medicare Cost	<p>Member who is enrolled under a Medicare Cost contract between Health Plan (or subsidiary or affiliated health plan) and CMS and for whom Medicare is the primary payer for purposes of this Agreement</p>	<p>Medicare</p>

* In each case, "member" includes the subscriber and any eligible dependents, in accordance with the terms of the applicable membership agreement.

MEMBERSHIP TYPE	MEMBERSHIP DEFINED	COVERED BENEFITS DEFINED BY:
Regular Medicare (Medicare unassigned)	<p>Members:</p> <p>(i) entitled to Medicare coverage under:</p> <ul style="list-style-type: none"> • Part A only, or • Part B only, or • Parts A and B but are not enrolled under a Medicare Advantage contract, or • a Medicare Cost contract between Health Plan (or another Kaiser Payer) • and CMS for whom the Medicare program is the primary payer for Medicare-covered services under Medicare reimbursement rules, or <p>(ii) enrolled under a Medicare Advantage contract and are hospice patients receiving care from Provider for Services unrelated to the hospice patient's terminal condition</p>	<p>Dual Coverage:</p> <p>Two separate plans</p> <ul style="list-style-type: none"> • the primary Medicare benefits are defined by Medicare, and • the Health Plan benefits are defined by the Membership Agreement (and the Employer Group if applicable).
State Programs (Medi-Cal, Medicaid, Healthy Families)	Contact Member Services for detailed information specific to your geographic area	Contact Affiliate Link for detailed information specific to your geographic area
Added Choice (POS)	Members who are working and part of an employer group	<p>Health Plan (HMO) benefits determined by the Membership Agreement.</p> <p>Allows members to choose from three provider options to obtain healthcare coverage that best meets their needs.</p> <p>Your agreement and this Provider Manual apply only to services that are Health Plan covered benefits.</p>

5.2 MEDICAL RECORD NUMBER

A unique Medical Record Number (MRN) is assigned to each member and is also listed on the front of the member's identification card. The MRN is used by Kaiser Permanente to identify the member's medical record, eligibility, and benefit level. If a member's enrollment terminates and the member re-enrolls at a later date, the member retains the same MRN although employer or other information may change. The MRN enables medical records/history to be tracked for all periods of enrollment.

Note: The MRN should be used as the "Member ID" when submitting bills or encounter data. Please refer to the "Billing and Payment" section of this Provider Manual for additional information.

5.3 MEMBER IDENTIFICATION CARDS

Kaiser Permanente issues a Health Plan Member Identification (ID) card to each member. The ID card for the appropriate benefit plan/type of coverage is included in the New Member Enrollment Packet sent to members. Members are instructed to present their ID card each time they access services.

All Kaiser Permanente ID cards include:

- Member Name
- Medical Record Number (MRN)
- Emergency information for non-Kaiser Permanente facilities

For record-keeping purposes, your business office may wish to photocopy the front and back of a member's identification card and place it in the member's medical records file.

For a sample of your region's Member Identification Card, please contact the specific region's Affiliate Link's department at the email listed in section 5.1, or in the "Key Contacts" section of this Provider Manual.

5.4 VERIFICATION OF ELIGIBILITY

Providers must verify the member's eligibility each time a member presents themselves for services. After receiving their Kaiser Permanente identification card, members may lose their eligibility or change health plans. Unless a referral and/or authorization has been received, they must verify the member's eligibility before rendering the service prior to the member presenting for services.

- Please do not assume that because a person has a Kaiser Permanente ID Card that coverage is in effect. Please check a form of photo identification to verify the identity of the member.
- Affiliate Link can always be contacted to verify the validity of the ID card/number; otherwise, providers provide services at their own financial risk.

Link for Eligibility:

[Eligibility and Benefits | National Contracting | Kaiser Permanente](#)

5.5 AFTER HOUR ELIGIBILITY REQUESTS

Members who may require clinical care after normal business hours must have their eligibility verified during the next business day. During the interim, providers must request that the member complete a financial responsibility form that places payment responsibility on the member in the event the member is found to be ineligible.

Eligibility verification or a financial responsibility form is not required for provision of emergency services; however, Kaiser Permanente will not pay for services provided if the person is not a Kaiser Permanente member.

5.6 BENEFIT COVERAGE DETERMINATION

In addition to eligibility, providers must determine that the member has coverage for services prior to providing such services to a member, usually by an authorization from Kaiser Permanente. The "Utilization Management" and "Claims" sections of this Provider Manual provide information regarding authorizations and referrals.

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