

## 3. Eligibility and Benefits Determination

### **3.1 Eligibility and Benefit Verification**

Providers are responsible for verifying Members' eligibility and benefits. Each time a Member presents at the office for services, Providers should:

- Verify the patient's current eligibility status
- Verify covered benefits
- Obtain necessary authorizations (if applicable)

Do not assume that eligibility is in effect because a person has a Health ID Card. Please check a form of photo identification to verify the identity of the Member. Except in an emergency situation, the Provider must verify that the Member has a benefit for the service prior to providing services.

Providers are invited and encouraged to request access to KP's **Online Affiliate** tool. Online Affiliate is enabled with a robust set of features that can help simplify the process of obtaining KP member information and performing claim reconciliation. Many actions can be performed with Online Affiliate, such as viewing patient eligibility/benefits, viewing detailed claim status, downloading Explanations of Payment (EOPs), filing disputes/appeals, submitting an online claim or payment inquiry and responding to KP requests for information (RFI). With access to Online Affiliate, these features are available on a self-serve basis 24 hours per day, 7 days per week. For more information and to initiate the provisioning process, please visit KP's Northern California Community Provider Portal at:

**<http://providers.kaiserpermanente.org/nca/>**

Alternately, contact the Member Services Contact Center (MSCC) to verify the Member's eligibility and benefits. It is important to verify the availability of benefits for services before rendering the service so the Member can be informed of any potential payment responsibility. If services are provided to a Member and the service is not a benefit or the benefit has been exhausted, denied or not authorized, KP may not be obligated to pay for those services.

Member Services Contact Center representatives are available Monday - Friday from 8AM to 5PM, Pacific Time (PT) at (888) 576-6789

By calling MSCC, providers may verify Member eligibility and benefits, and/or speak with a Member Services representative. Please be prepared to provide the Member's name and MRN which is located on the KP Health ID card.

Self-Service is available in the IVR System 24 hours per day, 7 days per week at (888) 576-6789.

### **3.1.1 After Hours Eligibility Requests**

Providers may contact KP 24 hours per day, 7 days per week to verify benefits and eligibility. Providers are invited and encouraged to request access to KP's Online Affiliate tool. Please see the Northern California Community Provider Portal (CPP) for more information at:

**<http://providers.kaiserpermanente.org/nca/>**

Alternately, you may call the IVR system of the KP Member Services Contact Center to verify benefits and eligibility 24 hours per day, 7 days per week at: **(888) 576-6789**.

You may also request the patient complete a financial responsibility form that places payment responsibility on the patient in the event they are later found to be ineligible as a Member or the care provided is not a covered benefit. A financial responsibility form is not required for provision of emergency services; however, KP will not pay for emergency or other unauthorized services provided if the person is not a Member.

### **3.1.2 Benefit Coverage Determination**

In addition to eligibility, Providers must confirm that the Member has coverage for the services at issue prior to providing such services to a Member, usually by requesting an authorization or receiving a referral from KP. Section 4.3 of this Provider Manual provides further details on the process for obtaining referrals and authorizations, except in cases of emergency.

## **3.2 Membership Types**

The table below generally describes the different HMO membership types.

<b>Membership Type</b>	<b>Membership Defined</b>	<b>Covered Benefits Defined By:</b>
Commercial	Members who purchase HMO coverage on an individual basis (other than Medicare) Members who are covered as part of an employer group and are not Medicare-eligible	Evidence of Coverage (EOC)
Medicare Advantage (formerly known as Medicare + Choice) (aka Senior Advantage)	Individual Medicare beneficiaries who have assigned their Medicare benefits to KP by enrolling in the KP Senior Advantage Program	Medicare, with additional benefits provided by KP as described in the EOC
	Employer group retirees or otherwise Medicare-eligible employees who are also Medicare beneficiaries and have assigned their Medicare benefits to KP by enrolling the KP Senior Advantage Program	Medicare, with additional benefits provided by KP as described in the EOC
Regular Medicare (Medicare unassigned)	Members who are eligible for, and enrolled in, Medicare and for whom Medicare is the primary payor, but who also have employer group commercial coverage, and who have not enrolled in the KP Senior Advantage nor Medicare Cost programs	Dual Coverage: Two separate plans – the primary Medicare benefits are defined by Medicare; the HMO benefits are defined by the EOC
State Programs (Medi-Cal, Healthy Families)	Contact the Member Services Contact Center (MSCC) for detailed information specific to your geographic area.	Contact MSCC for detailed information specific to your geographic area.

### **3.3 Benefit Exclusions and Limitations**

KP benefit plans may be subject to limitations and exclusions. Before rendering services, it is important to contact MSCC to obtain information on, and verify the availability of, Member benefits for services so the Member can be informed of any potential payment responsibility.

If services are provided to a Member and the service is not a benefit, the benefit has been exhausted, denied or was not authorized, KP will not be obligated to pay for those services, except to the extent required by law.

### **3.4 Drug Benefits**

The drug benefits vary based on the benefit plan. To verify if a Member has a drug benefit, please contact MSCC.