State of California—
Health and Human Services Agency

California Department of Public Health

Health Insurance Premium Payment Assistance
Medical Out–of–Pocket Program

Program Benefits

Who is covered?

(1.) ADAP clients who are also receiving health insurance premium payment assistance through the OA-HIPP program.

(2.) Spouses and/dependents of HIPP clients, who are also enrolled in ADAP.

What is covered?

Outpatient expenses that count towards your insurance plan's out-of-pocket maximum, which are the copayment, coinsurance, and deductible for medical care as part of the plans covered benefits. **Note**: All claim submissions must be for expenses incurred during your active HIPP eligibility period.

Billing and Claim Submissions

Obtaining required supporting documentation for services received

(1.) Provide your medical provider with your PAI-CDPH HIPP Program identification card.

(2.) Request a medical billing statement or invoice from your provider.

(3.) After your appointment, you should receive an Explanation of Benefits (EOB) from your insurance company.

Note: If you do not receive an EOB, you should contact your insurance company to request one. If you have difficulty obtaining an EOB, please contact PAI directly at (877) 495-0990 for further instruction on acceptable submission documentation.

Submitting a Claim to PAI

To submit a claim to PAI, the following must be included:

(1.) Medical Out-of-Pocket Claim Form (See attachment 1),

(2.) Billing statement/invoice, and

(3.) EOB

Note: One Medical Out-of-Pocket Claim Form is required for each date of service and provider. For example, if you visit multiple providers on the same day, you will need to submit each claim individually.

Claims can be sent using one of the following methods:

(1.) Fax: (860) 560-8225

(2.) Email: CDPH_MBM_Fax@pooladmin.com

(3.) Standard mail:

P A I - CDPH
628 Hebron Avenue, Suite 100
Glastonbury, CT 06033

Reimbursement

How will you be reimbursed?

The HIPP program pays the reimbursement directly to the provider. If you are required to pay at the time of service, one of the following should occur:

(1.) Provider issues the reimbursement directly to you upon receipt of the payment from PAI, or

(2.) Provider will apply the reimbursement as a credit on your account.

If you are not required to pay at the time of service, one of the following should occur:

(1.) The provider should work directly with PAI and submit the claim on your behalf for payment, or

(2.) You can submit the claim and PAI will submit the payment to the provider on your behalf.

Claim Denial

What could cause a claim to be denied?

(1.) Ineligible dates of service

(2.) Unauthorized expense: not covered by medical insurance

(3.) Any expense that is listed as "Not Covered by the Primary Insurer". For example, elective out patient surgeries may not be covered by primary insurance and would not be reimbursable by CDPH.

(4.) Unauthorized expense: medical service is out of network

(5.) Unauthorized expense: Inpatient service

(6.) Service does not count toward your annual out of pocket maximum

(7.) Client name does not match the invoice

(8.) Supporting documentation not provided within 21 days of the Information Request letter being sent

(9.) Cost of Service does not match the supporting documentation

(10.) Other

Note: If you receive a denial letter, you have 20 days from the date of the letter to file an appeal.

Request for More Information (See Attachment 2)

You may receive a request for more information in the following circumstances:

(1.) Supporting documentation was not provided

(2.) Supporting documentation is incomplete. Please send provider billing invoice

(3.) Supporting documentation is incomplete. Please send insurance Explanation of Benefits

(4.) Supporting documentation is illegible

(5.) Supporting documentation does not match date of service

(6.) Supporting documentation does not match submitted request

(7.) Supporting documentation does not match requested claim reimbursement amount

(8.) Other

Note: You have 21 days from the date of the letter to provide PAI with the requested documentation.

Reminder: A provider is not obligated to waive any co-payments that are due at the time of service. If your provider does require payment at the time of service, you are encouraged to ask the provider to contact PAI directly to discuss the program in more detail.

Additionally, in accordance with IRS guidelines, providers are required to submit completed W9s to PAI prior to PAI remitting payment. PAI will contact the provider to obtain the W9 if one is not already on file.

Attachment 1: Sample Medical Out-of-Pocket Claim Form

CDPH 205909 PAI

Insurance Premium Payment Assistance Medical Out-of-Pocket Claim Form

Submitter must complete Sections A and B. This claim form AND supporting documentation must be sent to Pool Administrators, Inc. (PAI)

- Fax: (860) 560-8225
- Email: CDPH_MBM_Fax@pooladmin.com
- Mail: PAI-CDPH, 628 Hebron Ave., Suite 100, Glastonbury, CT 06033

If you have any questions about submitting this form, please contact PAI Customer Service at (877) 495-0990.

A. Client Information

SAMPLE	CLIENT	01/01/01	12345678
First Name	Last Name	Date of Birth	Client ID Number

Client Mailing Address: 123 Main St. MYTOWN, CA 00000
Street/PO Box City State Zip Code

☐ Spousal Claim
Language Preference: ☒ English ☐ Spanish ☐ Other: _____

B. Service and Provider Information

Type of Service (select one):
☒ Lab
☐ Provider Visit
☐ Other (please specify): _____
☐ Radiology/X-ray/Imaging
☐ Emergency/Urgent Care

4-27-17	$ 20.00
Date of Service	Client's Out of Pocket Cost Amount

Quest Diagnostics	1-800-7586047	
Provider Name (Print)	Provider Phone Number	Provider Fax Number

C. Enrollment Worker Information

Enrollment Worker Name	Enrollment Worker Phone Number	Enrollment Worker Email Address

D. Pool Administrators Use Only

Received By	Date Received	Date Updated

Comments by Pool Administrators (Check all that apply):

☐ **Approved:**
PAI Payment Date: _____ Payment Amount: _____
PAI Check Number: _____ Check Memo Line: _____
☐ **Denial Reason:** _____
☐ **Pending Reason:** _____
☐ **Appeal Reason:** _____
Date received: _____ Date responded: _____

Attachment 2: Sample of Information Request Letter

Sample Information Letter

Information Request

<First Name Last Name>
<Address 1>
<Address 2>
<City, State, Zip>

Date <Month DD, YYYY>

Re: Claim Number: <Insert Claim number>
Provider/Payee Name: <Insert Provider/Payee Name>
Date of Service: <Insert Date of Service>
Claim Request Amount: <Insert Claim Request Amount>

Dear <Insert First Name Last Name>,

This letter is to inform you that the evaluation of your reimbursement request for outpatient out of pocket medical costs submitted to the California Department of Public Health (CDPH) insurance premium payment assistance program has been delayed for the reason noted below.

Select one :(Common Reasons for information request to be selected from the administration system chosen from a system drop-down menu)

- Supporting documentation was not provided
- Supporting documentation is incomplete. Please send provider billing invoice
- Supporting documentation is incomplete. Please send insurance Explanation of Benefits
- Supporting documentation is illegible
- Supporting documentation does not match date of service
- Supporting documentation does not match submitted request
- Supporting documentation does not match requested claim reimbursement amount
- Other (An 80-character editable field will be available for input)

Acceptable types of supporting documentation must include; your name, the date of service, service provider name, the type of outpatient medical service you received, and your out of pocket cost. You may find this information on an invoice, claim, or an Explanation of Benefits. The documentation submitted must be legible. *Always note the Claim Number* <Insert Claim Number> on all supporting documents submitted that are associated with this request.

Please submit the required documentation to Pool Administrators Incorporated (PAI), using one of the following methods:

1. Fax: (860) 560-8225
2. Email: CDPH_MBM_Fax@pooladmin.com
3. Mail: PAI-CDPH, 628 Hebron Avenue, Suite 100, Glastonbury, CT 06033

If you have any questions, please contact the PAI customer service team at (877) 495-0990. **Your response is required within 21 days from the date of this letter. Otherwise, your claim will be denied.**