Medicare Part D Premium Payment (MDPP) Assistance
Medical Out–of–Pocket (MOOP) Program

Program Benefits

Who is covered?
ADAP clients who are also receiving health insurance premium payment assistance through the MDPP program.

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 policy's covered benefits.

Note: All claim submissions must be for expenses incurred during your active MDPP eligibility period.

Billing and Claim Submissions

Obtaining required supporting documentation for services received

(1.) Provide the medical provider with the PAI-CDPH identification card.

(2.) Request a medical billing statement or invoice from the provider. (3.) After the client’s appointment, the client should receive an Explanation of Benefits (EOB) from their insurance company.

Note: If the client does not receive an EOB, they should contact their insurance company to request one. If the client has 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, also available on the CDPH website at http://www.cdph.ca.gov/Programs/CID/DOA/PagesOA_adap_forms.aspx),

(2.) Billing statement/invoice (See attachment 2)

(3.) EOB (See attachment 3)
**Note:** One Medical Out-of-Pocket Claim Form is required for each date of service and provider. For example, if the client visits multiple providers on the same day, they will need to submit each claim individually.

Claims can be sent using one of the following methods:

<table>
<thead>
<tr>
<th>Filer</th>
<th>Method</th>
<th>Documents Required</th>
</tr>
</thead>
</table>
| Client  | Paper   | Complete and submit CDPH MOOP Claim Form, supporting documentation such as invoice or receipt, and Explanation of Benefits from insurance plan to CDPH's Medical Benefits Manager, Pool Administrators, Inc. (PAI) at:  
  - Fax: (860) 560-8225  
  - Email: CDPH_MBM_Fax@pooladmin.com  
  - Mail: PAI-CDPH-02, 628 Hebron Ave., Suite 502, Glastonbury, CT 06033 |
| Providers | Paper | Complete and submit CDPH MOOP Claim Form, supporting documentation such as invoice or receipt, and Explanation of Benefits from insurance plan to PAI at:  
  - Fax: (860) 560-8225  
  - Email: CDPH_MBM_Fax@pooladmin.com  
  - Mail: PAI-CDPH-02, 628 Hebron Ave., Suite 502, Glastonbury, CT 06033 |
| Providers | Electronic | Call PAI customer service at (877) 490-0990 to establish electronic claims submission and automated payments.  
  Use payer ID PAI02 when submitting electronic claim forms for MDPP clients. |

**Reimbursement**

**How will the client be reimbursed?**

PAI pays the reimbursement directly to the provider. If the client is required to pay at the time of service, one of the following should occur:

1. Provider issues the reimbursement directly to the client, or
(2.) Provider will apply the reimbursement as a credit on the client’s account.

If the client is 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 the client’s behalf for payment, or

(2.) The client submits the claim and PAI will submit the payment on the client’s 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 outpatient 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 a client receives a denial letter, they have 20 days from the date of the letter to file an appeal.

Request for More Information (See Attachment 4)

A client 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:** A client has 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 the client’s provider does require payment at the time of service, the client is 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

State of California-Health and Human Services Agency

PAI

California Department of Public Health

Insurance Premium Payment Assistance Medical Out-of-Pocket Claim Form
Submitter must complete Sections A and B. This claim form AND supporting documentation (Explanation of Benefits and an invoice) must be sent to Pool Administrators, Inc. (PAI). If you have any questions about submitting this form, please contact PAI Customer Service at (877) 495-0990.
Fax: (860) 560-8225
Email: CDPH_MBM_Fax@pooladmin.com
Mail: PAI-CDPH, 628 Hebron Ave., Suite 100, Glastonbury, CT 06033

A. Client Information
First Name: SALLY
Last Name: SAMPLE
Date of Birth: 1/1/1980
Client ID number: 12345678
Client Mailing Address: 123 MAIN STREET
City: ANYTOWN
State: CA
Zip Code: 99999

☐ Spousal Claim

Language Preference: ☐ English ☐ Spanish ☐ Other: ________________

B. Service and Provider Information
Type of Service (select one):
☐ Lab
☐ Radiology/X-ray/Imaging
☐ Provider Visit
☐ Emergency/Urgent Care
☐ Other (please specify): ________________
Date of Service: 4/27/2017
Client's Out of Pocket Cost Amount: $20.00
Provider Name: SAMPLE DIAGNOSTICS
Phone number: 800-999-9999
Fax number: ________________

C. Enrollment Worker Information
Name: E. WORKER
Phone number: ________________ Email: ________________

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: ________________

☐ Denial Reason: ________________ Check Memo Line: ________________

☐ Pending Reason: ________________

☐ Appeal Reason: ________________

Date received: ________________ Date responded: ________________

CDPH 8443 (4/17)
**Attachment 2: Sample Invoice**

### Laboratory Invoice

**Invoice Date:** May 16, 2017  
**Amount Due:** $20.00  
**Due Date:** Jun. 06, 2017

**Invoice Number:**  
**Lab Code:**

**Patient Name:**  
**Reason for Referral:**  
**Date of Service:** Jan. 24, 2017

**Lab Results and Diagnosis Questions Must Be Answered By Your Physician.**

### Laboratory Tests Were Requested By:

**Referring Physician:**  
**Physician Address:**

### Most Recent Insurance Claim Filed To:

**Insurance Name:** BLUE CROSS COB  
**Insurance ID:**  
**Group Number:**

This Invoice is for laboratory tests performed at the request of the referring physician. These charges are separate from the physician’s fees. BLUE CROSS COB indicates the balance is your co-payment, co-insurance, or deductible and is your financial responsibility. Prompt payment is appreciated. Thank you for using our laboratory.

<table>
<thead>
<tr>
<th>Date</th>
<th>CPT Code</th>
<th>Test Description</th>
<th>Charge</th>
<th>Insurance Discount</th>
<th>Insurance Paid</th>
<th>Medicare/Covered Folio</th>
<th>Patient Part</th>
<th>Patient Share</th>
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<tbody>
<tr>
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<td>68380</td>
<td>T-CELLS, IMMUNE FUNCTION</td>
<td>$34.68</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>04/27/17</td>
<td>68685</td>
<td>T CELLS, TOTAL COUNT</td>
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<td>66056</td>
<td>CMV/ADENOVIRUS/CMV ELISA</td>
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<tr>
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<td>VG, TREPONEMA PALUMUM</td>
<td>$61.00</td>
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</table>

**Received:** May 31, 2017

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**Log On Now:** Pay your bill online securely at www.QuestDiagnostics.com or call 1-855-394-4861.

**Quest Diagnostics also accepts:**

- VISA
- MASTERCARD
- DISCOVER
- AMERICAN EXPRESS

Please make checks payable to Quest Diagnostics. Be sure to include invoice number on your check.

Check here if address has changed. Please provide your new address information on the back. Quest Diagnostics reserves the right to reject this application to avoid its address.

**Amount Due:** $20.00  
**Due Date:** Jun. 06, 2017  
**Invoice Number:**

**Amount Enclosed:** $

If you received an explanation of benefits showing your responsibility is less than the amount shown on this bill, please pay the lesser amount. To fully resolve any invoice, please provide a copy of your explanation of benefits.

**MAIL PAYMENTS ONLY TO:**

**QUEST DIAGNOSTICS**  
P.O. BOX 760877  
CINCINNATI, OH 45276-0877

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## Medical services payment detail

*Date claimed received: 06/34/17*
*Provider: QUICK DIAGNOSTICS*
*Claim number: 1234*
*Network status: In-network*
*Patient account: 1234*

### Your health benefits paid

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Amount charged by your provider</th>
<th>Amount discounted</th>
<th>Amount due to your provider</th>
<th>Anthena Blue Cross/Blue Shield</th>
<th>Copay</th>
<th>Deductible</th>
<th>Balance</th>
<th>Services not covered</th>
<th>Total you pay for any services shown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services provided for:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAMPLE CLIENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4/27/17</td>
<td>Urology</td>
<td>225.50</td>
<td>20.50</td>
<td>2.00</td>
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<tr>
<td>4/27/17</td>
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<td>4/27/17</td>
<td>Lab Hematology</td>
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<td>0.00</td>
<td>0.00</td>
<td>10.62</td>
</tr>
</tbody>
</table>

**Total for SAMPLE:** 1,285.70

You have received total services above here, including diagnostic and treatment codes and what they mean. Just call Member Services at 855-824-0381.

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Attachment 4: Sample Information Request Letter

Sample Information Letter
Information Request

<First Name Last Name> 
<Date <Month DD, YYYY>>

<Address 1>
<Address 2>
<City, State, Zip>

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) 500-8225
2. Email: CDPH_NBM_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.