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:

Filer	Method	Documents Required
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, Glasonbury, 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 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 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
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: _____

PAI Check Number: _____ Check Memo Line: _____

☐ **Denial Reason:** _____

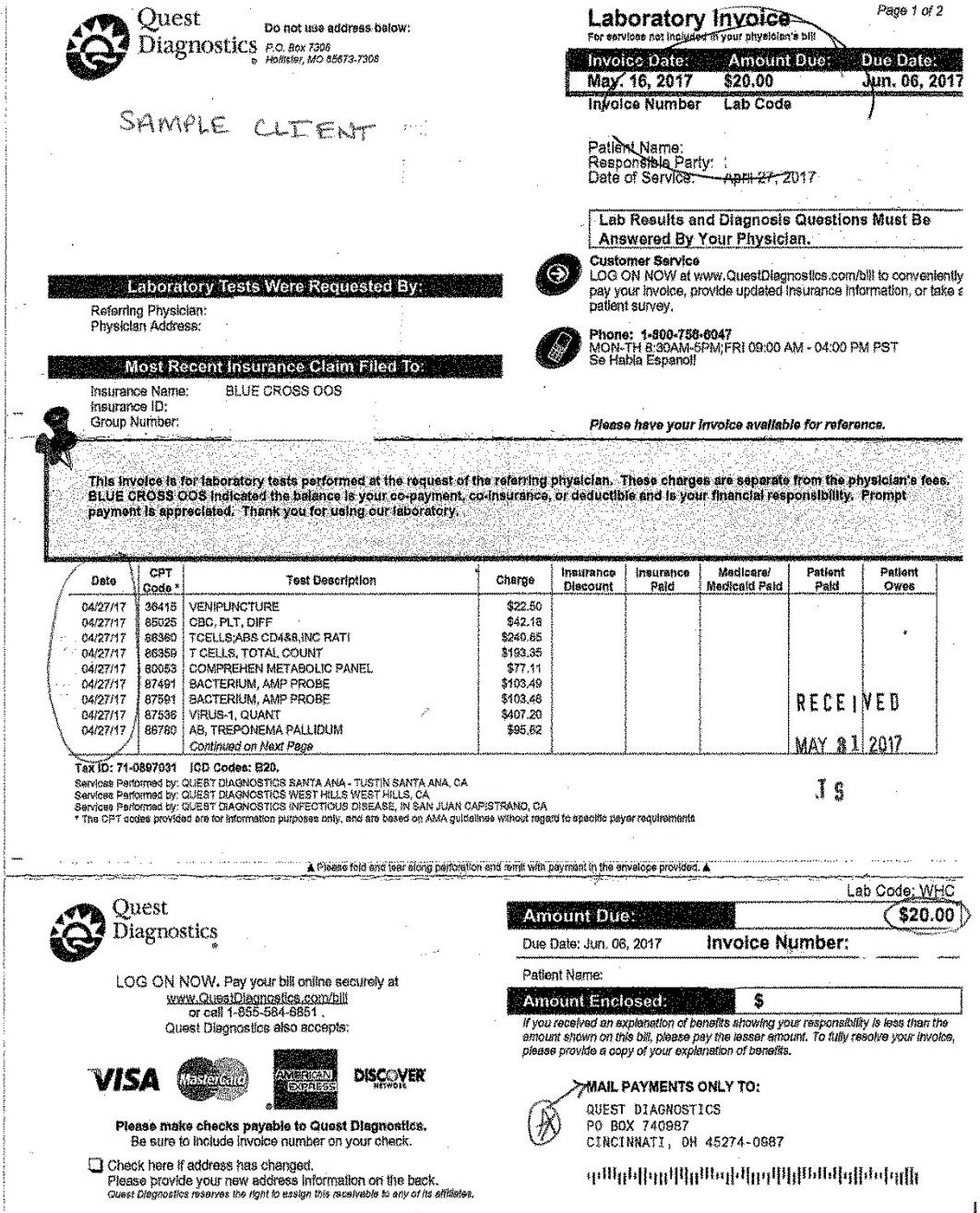
☐ **Pending Reason:** _____

☐ **Appeal Reason:** _____

Date received: _____ Date responded: _____

CDPH 8443 (4/17)

Attachment 2: Sample Invoice



Quest Diagnostics

Do not use address below:
P.O. Box 7306
Hollister, MO 65673-7306

SAMPLE CLIENT

Laboratory Invoice
For services not included in your physician's bill

Page 1 of 2

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

Invoice Number Lab Code

Patient Name:
Responsible Party:
Date of Service: April 27, 2017

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

Customer Service
LOG ON NOW at www.QuestDiagnostics.com/bill to conveniently pay your invoice, provide updated insurance information, or take a patient survey.

Phone: 1-800-758-6047
MON-TH 8:30AM-5PM;FRI 09:00 AM - 04:00 PM PST
Se Habla Espanol!

Laboratory Tests Were Requested By:
Referring Physician:
Physician Address:

Most Recent Insurance Claim Filed To:
Insurance Name: BLUE CROSS OOS
Insurance ID:
Group Number:

Please have your invoice available for reference.

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 OOS indicated 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.

Date	CPT Code *	Test Description	Charge	Insurance Discount	Insurance Paid	Medicare/ Medicaid Paid	Patient Paid	Patient Owes
04/27/17	36415	VENIPUNCTURE	$22.50					
04/27/17	85025	CBC, PLT, DIFF	$42.18					
04/27/17	86360	TCELLS;ABS CD4&8,INC RATI	$240.65					
04/27/17	86359	T CELLS, TOTAL COUNT	$193.35					
04/27/17	80053	COMPREHEN METABOLIC PANEL	$77.11					
04/27/17	87491	BACTERIUM, AMP PROBE	$103.49					
04/27/17	87591	BACTERIUM, AMP PROBE	$103.46					
04/27/17	87536	VIRUS-1, QUANT	$407.20					
04/27/17	86780	AB, TREPONEMA PALLIDUM	$95.62					
		Continued on Next Page						

RECEIVED
MAY 31 2017

Tax ID: 71-0897031 ICD Codes: B20,
Services Performed by: QUEST DIAGNOSTICS SANTA ANA - TUSTIN SANTA ANA, CA
Services Performed by: QUEST DIAGNOSTICS WEST HILLS WEST HILLS, CA
Services Performed by: QUEST DIAGNOSTICS INFECTIOUS DISEASE, IN SAN JUAN CAPISTRANO, CA
* The CPT codes provided are for information purposes only, and are based on AMA guidelines without regard to specific payer requirements

▲ Please fold and tear along perforation and remit with payment in the envelope provided. ▲

Quest Diagnostics

LOG ON NOW. Pay your bill online securely at
www.QuestDiagnostics.com/bill
or call 1-855-584-6851 .
Quest Diagnostics also accepts:

VISA MasterCard AMERICAN EXPRESS DISCOVER NETWORK

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 assign this receivable to any of its affiliates.

Lab Code: WHC

Amount Due: $20.00

Due Date: Jun. 06, 2017 **Invoice Number:**

Patient Name:

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 your invoice, please provide a copy of your explanation of benefits.

MAIL PAYMENTS ONLY TO:
QUEST DIAGNOSTICS
PO BOX 740987
CINCINNATI, OH 45274-0987

Attachment 3: Sample Explanation of Benefits (EOB)

Medical services payment detail
as of 5/05/2017

Services provided for:	Claim number	Date claim received	Provider	Network status	Patient account
SAMPLE CLIENT	1234	05/04/17	QUEST DIAGNOSTICS	In-network	1234

						Your health benefits paid	You pay				
Day you got care	Services received	Reason code	Amount charged by your provider	Your discounts −	Amount due to your provider =	Anthem Blue Cross paid −	Copay +	Deductible +	Coinsurance +	Services not covered +	Total you pay for may have paid =
4/27/17	Venipuncture	066 135	22.50	20.40	2.10	0.00	2.10	0.00	0.00	0.00	2.10
4/27/17	Lab Hematology	066 135	42.18	35.24	6.94	0.00	6.94	0.00	0.00	0.00	6.94
4/27/17	Lab Immunology	066 135	240.85	186.92	41.93	30.97	10.96	0.00	0.00	0.00	10.96
4/27/17	Lab Immunology	066	183.35	159.69	33.66	33.66	0.00	0.00	0.00	0.00	0.00
4/27/17	Lab Panel	066	77.11	67.68	9.43	9.43	0.00	0.00	0.00	0.00	0.00
4/27/17	Lab Microbiology	066	103.48	72.17	31.32	31.32	0.00	0.00	0.00	0.00	0.00
4/27/17	Lab Microbiology	066	103.48	72.16	31.32	31.32	0.00	0.00	0.00	0.00	0.00
4/27/17	Lab Microbiology	066	407.20	331.27	75.93	75.93	0.00	0.00	0.00	0.00	0.00
4/27/17	Lab Immunology	066	95.62	83.81	11.81	11.81	0.00	0.00	0.00	0.00	0.00
Subtotal			1,285.78	1,041.34	244.44	224.44	20.00	0.00	0.00	0.00	20.00

This provider is in your plan's network. This lets us use your in-network benefits to pay for covered services. Look for the "You pay" section above for what you owe.
135: THIS AMOUNT IS THE MEMBER'S COPAYMENT RESPONSIBILITY.
066: THIS IS THE AMOUNT IN EXCESS OF THE MAXIMUM ALLOWED AMOUNT FOR A PARTICIPATING PROVIDER. THE MEMBER, THEREFORE, IS NOT RESPONSIBLE FOR THIS AMOUNT.

Total for SAMPLE		1,285.78	1,041.34	244.44	224.44	20.00	0.00	0.00	0.00	20.00

You can learn more about services shown here, including diagnosis and treatment codes and what they mean. Just call Member Services at 855-634-3381.

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Attachment 4: Sample 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.**