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 the 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 the client’s active HIPP eligibility period.

Billing and Claim Submissions

Obtaining required supporting documentation for services received

(1.) Provide the medical provider with the PAI-CDPH HIPP Program 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),
(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:

(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 the client be reimbursed?**

The HIPP program 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

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

First Name: [Client First Name]
Last Name: [Client Last Name]
Client Mailing Address: 123 Main St, Anytown, CA
Date of Birth: 01/01/01
Client ID Number: [Client ID Number]
Street/PO Box: [Street/PO Box]
City: [City]
State: [State]
Zip Code: [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):

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

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:
Comments by Pool Administrators (Check all that apply):
☐ Approved:
- PAI Payment Date: [Payment Date]
- PAI Check Number: [Check Number]
- Payment Amount: [Payment Amount]
- Check Memo Line: [Memo Line]

☐ Denial Reason:
- Date received: [Date]

☐ Pending Reason:
- Date appealed: [Date]

☐ Appeal Reason:
- Date responded: [Date]
Attachment 2: Sample Invoice

Laboratory Invoice

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

Patient Name: Patient ID:
Lab Code:

Referring Physician:

Physician Address:

Most Recent Insurance Claim Filed To:

Insurance Name: BLUE CROSS OBS
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 OBS 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/Other Paid | Patient Paid | Patient Chose
--- | --- | --- | --- | --- | --- | --- | --- | --- | ---
04/27/17 | 54615 | VENIPUNCTURE | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50
04/27/17 | 88529 | CIG. PLT. DIFF | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50
04/27/17 | 88534 | T CELL ULTRASUSCEPTIBILITY PROFILE | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50
04/27/17 | 88539 | T CELLS, TOTAL COUNT | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50
04/27/17 | 46558 | COMPREHENSIVE METABOLIC PANEL | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50
04/27/17 | 67491 | BACTERIUM, AMP PROBE | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50
04/27/17 | 55994 | BACTERIUM, AMP PREX | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50
04/27/17 | 61356 | VIRUS, QUANT | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50
04/27/17 | 187762 | A. S. TREPONEMA PALPLOU | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50 | $22.50

Total: $20.00

Please leave your invoice available for reference.

Received
May 3, 2017

Lab Code: WHC

Amount Due: $20.00
Due Date: Jun. 08, 2017
Invoice Number:

Payment:

Amount Enclosed: $0

If you received an explanation of benefits showing 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 740667
CINCINNATI, OH 45274-6667

Please mail checks payable to Quest Diagnostics.

Quest Diagnostics also accepts:

Visa | MasterCard | Discover

Please make checks payable to Quest Diagnostics.

Check here if address has changed.

Please provide your new address information on the back. Quest Diagnostics reserves the right to decline this reimbursement to any of its affiliates.
### Attachment 3: Sample Explanation of Benefits (EOB)

**Medical services payment detail**

**As of 9/04/2017**

<table>
<thead>
<tr>
<th>Date claim received</th>
<th>Provider</th>
<th>Network status</th>
<th>Patient account</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/04/17</td>
<td>QUEST DIAGNOSTICS</td>
<td>In-network</td>
<td>1234</td>
</tr>
</tbody>
</table>

**Your health benefits paid**

<table>
<thead>
<tr>
<th>Service Received</th>
<th>Amount covered by your provider</th>
<th>Total benefits due to your provider</th>
<th>Anthem Blue Cross paid</th>
<th>You pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/27/17 Lab Hematology</td>
<td>166.61</td>
<td>166.61</td>
<td>10.97</td>
<td>10.97</td>
</tr>
<tr>
<td>4/27/17 Lab Hematology</td>
<td>166.61</td>
<td>166.61</td>
<td>10.97</td>
<td>10.97</td>
</tr>
<tr>
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<td>166.61</td>
<td>166.61</td>
<td>10.97</td>
<td>10.97</td>
</tr>
</tbody>
</table>

This provider is in your plan's network. This lets us see your in-network benefits to pay for covered services. Look for the "You pay" section above for what you owe.

**EOB:** This amount is the Member's Copayment Responsibility.

**OA:** 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**

<table>
<thead>
<tr>
<th>Amount</th>
<th>Total Benefits Due</th>
<th>Anthem Blue Cross Paid</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,259.79</td>
<td>1,361.94</td>
<td>241.44</td>
<td>20.00</td>
</tr>
</tbody>
</table>

You can learn more about services shown here, including diagnostic and treatment codes and what they mean. Just call Member Services at 435-636-0381.
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 of 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) 580-8225
2. Email: CDPH_MBM_Fax@pooladmin.com
3. Mail: PAI-CDPH, 626 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.