OTHER HEALTH COVERAGE REFERENCE GUIDE

OHC Addition and Removal Requests

OVERVIEW:

This guide is to be used as a reference to submit an OHC Addition or Removal request. Individuals requesting updates to their Other Health Coverage (OHC) must either submit a request for an OHC Addition or Removal by completing the fillable form located on the DHCS website or by submitting their request via the Telephone Service Center toll free number (800 541-5555).

KEY NEW FEATURES:

- Requests for removal and additions can be submitted via the same form.
- Requests for multiple members (i.e. family members) can be made at one time (no need to submit separate requests).
- Time limit has been removed from the form, allowing additional time for submission.

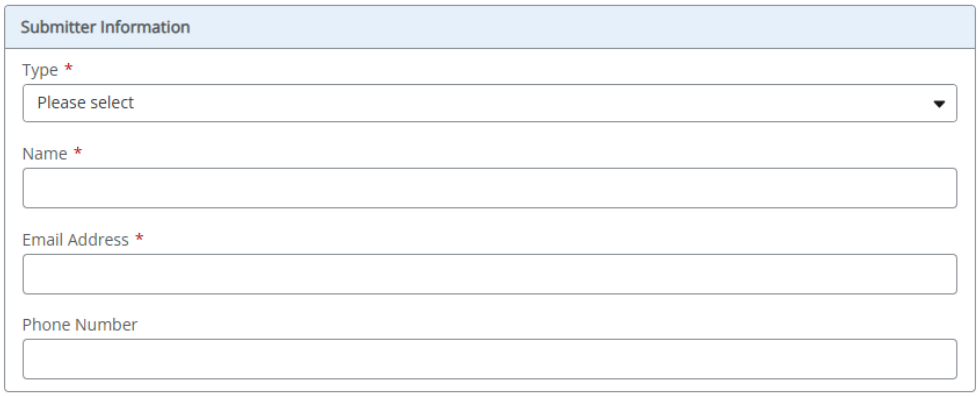
SUBMITTER INFORMATION:

1. Submitter Type – Who is submitting the request? (i.e. County Worker, Insurance Carrier, Health Provider, Managed Care Plan, DHCS Employee, or Telephone Service Center)

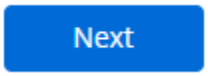
2. Submitter's Name – Name of the submitter.

3. Email Address – Submitter's **valid** email address. This information is used to contact the submitter if discrepancies arise and used to notify the submitter of request status.

4. Phone Number – Submitter's **valid** phone number at which submitter can be contacted directly. This information is used to contact the submitter if discrepancies arise.

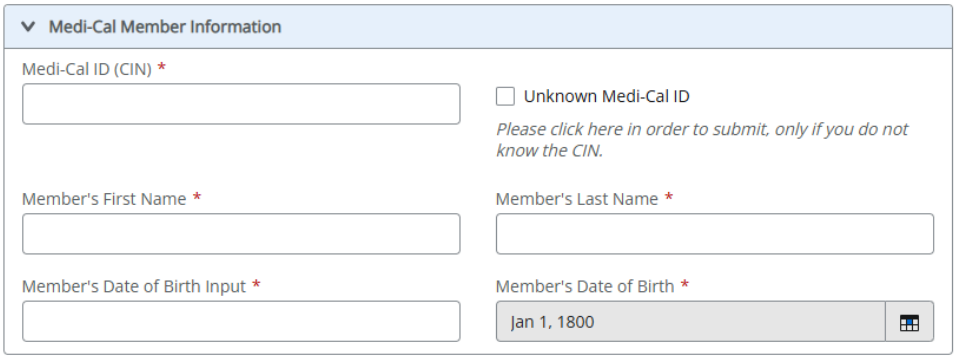


Once complete, press the "NEXT" button.



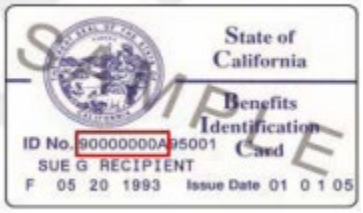
REQUEST DETAILS:

Medi-Cal Member Information

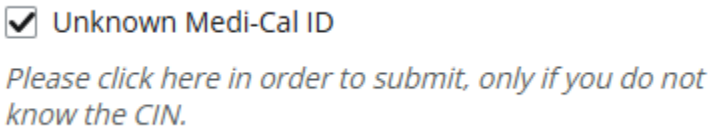


1. Medi-Cal ID (CIN) – The Client Index Number (CIN) is found on the Medi-Cal member's Benefits Identification Card (BIC). DO NOT use the member's Social Security Number (SSN) or Medi-Cal Case number also knows as the Serial Number (7-character alpha-numeric number).

CIN/ID # Examples:



   a. If the Medi-Cal ID/CIN is unknown, check the "Unknown Medi-Cal ID" checkbox. (The Medi-Cal ID field will no longer be required.)

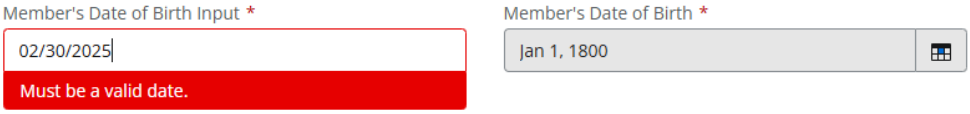


2. Member's First Name – First name of Medi-Cal member's having OHC removed/modified.

3. Member's Last Name – Last name of Medi-Cal member having OHC removed/modified.

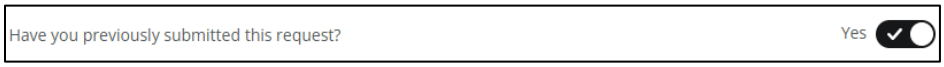
4. Member's Date of Birth Input – Use the member's complete date of birth in the following format: MM/DD/YYYY. **DO NOT use date of submission as the date of birth**.

a. If the date is invalid, the date validation field will show the date **Jan 1, 1800**. You will not be able to submit the form with an invalid date.



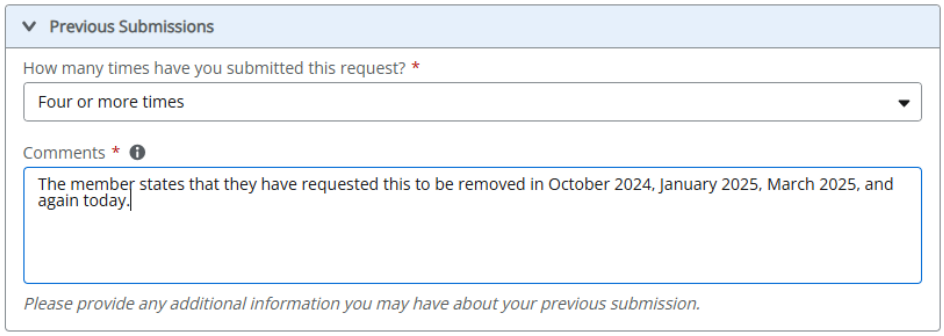
Optional: Previous Submissions

If you toggle the "Have you previously submitted this request" to Yes, the "Previous Submissions" subsection will appear.



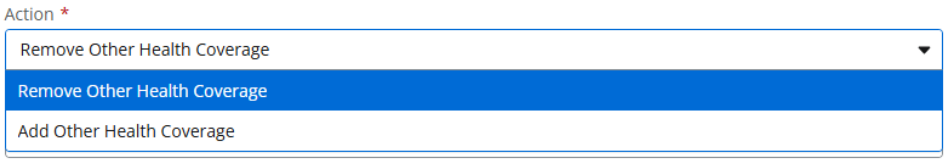
1. How many times have you submitted this request? – Select the number of times the OHC request has been submitted for the member for the specific OHC from the drop-down list.

2. If the request has been submitted more than once, provide details in the comment box.



Other Health Request(s)

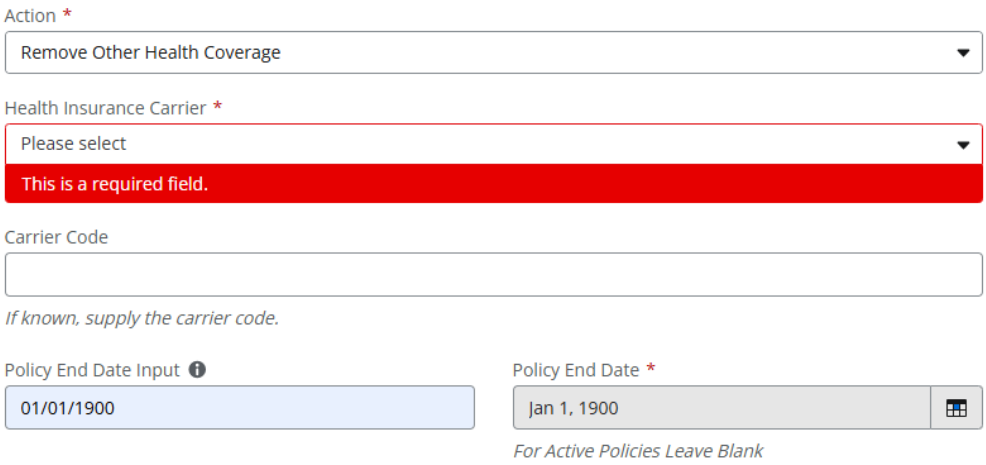
Action: Request **either** an OHC removal or an OHC addition.



OHC Removal Requests

1. Health Insurance Carrier: Select the carrier name from the drop-down list for the OHC being requested to be removed.
    a. If the carrier name is not on the list, select "Other" and provide the name in the "Health Insurance Carrier Name" comment box that appears.
    b. If the carrier name is unknown, select "Unknown."

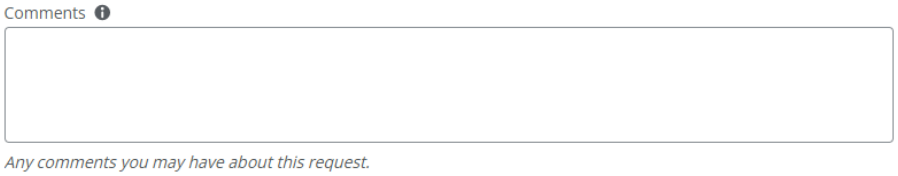
2. Carrier Code *(optional)* – Input the carrier code needing to be removed. The carrier code is a 4-character alpha-numeric number starting with a letter followed by three numbers (i.e. A000). The carrier code specifies which OHC is to be removed.
3. Policy End Date Input – If "Remove Other Health Coverage" is the selected action, the "Policy End Date" field will appear. Provide the date the OHC policy terminated in the following format: MM/DD/YYYY.
    a. If the member never had OHC, please type "01/01/1900" in the Policy Stop Date field. **DO NOT use 00/00/0000 or 12/31/9999.** These are invalid dates, which will prevent submission.



4. Reason for OHC Removal - Provide the reason why the OHC is being removed. Select one of the options from the drop-down list.
    a. If none of the options apply, select "Other Modifications (Please specify below)" and provide details in the comment box (see 6 below).

5. Remove All Health Insurance? *(optional)* - If the "Remove all Active OHC" option is toggled to "Yes", **ALL** active carrier codes will be removed.

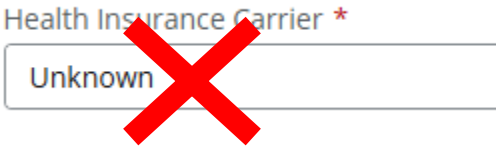
6. Comments – Add any additional comments or reasons for removal not previously specified.



OHC Addition Requests

1. Health Insurance Carrier - Select the carrier name from the drop-down list for the OHC being requested to be removed or added.
    a. If the carrier name is not on list, select "Other" and provide the name in the "Health Insurance Carrier Name" comment box that appears.

    b. While "Unknown" is an option, the Health Insurance Carrier **<u>must be known</u>** for an addition request to be completed. Submissions with "Unknown" selected will be <u>rejected</u> as insufficient by DHCS.

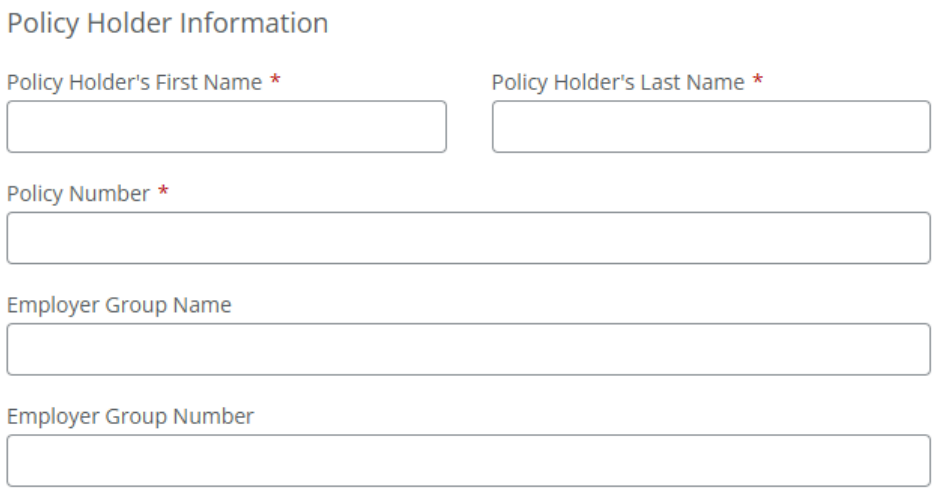


2. Carrier Code *(optional)* – Input the carrier code needing to be added. The carrier code is a 4-character alpha-numeric number starting with a letter followed by three numbers (i.e. A000).

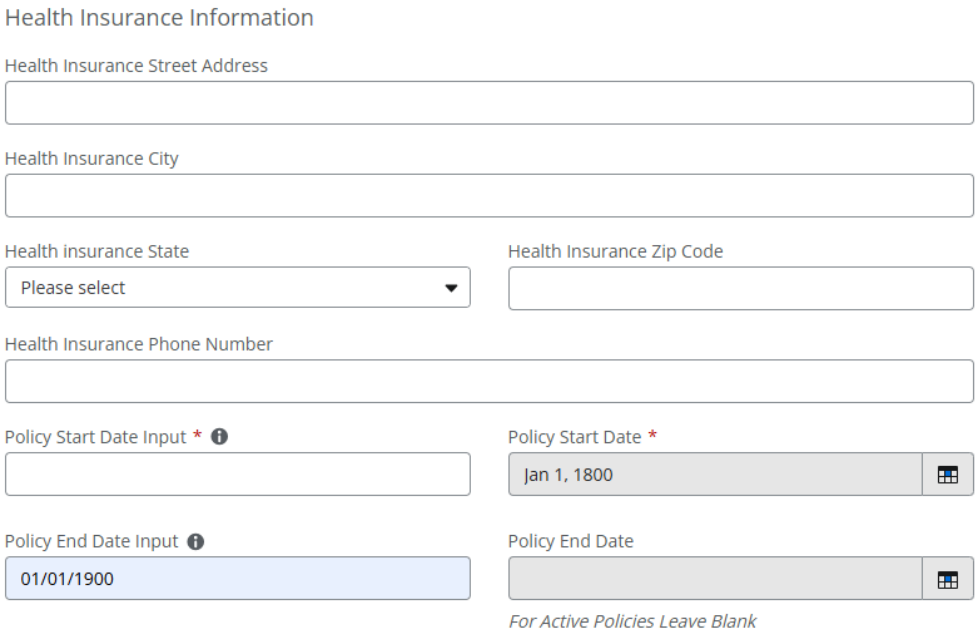
3. Health Insurance Type – Select the type of health insurance (PPO, HMO, Vision, etc.)

4. <u>Policy Holder Information</u>

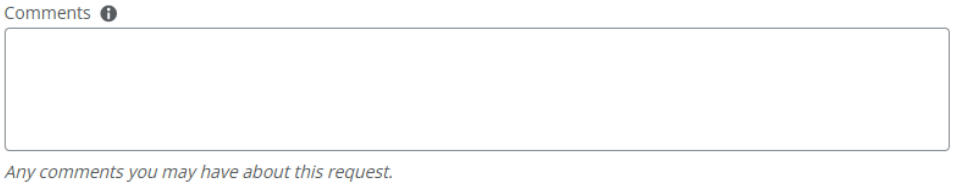
a. Policy Holder's First Name – First name of the primary policy holder for the health insurance plan.
b. Policy Holder's Last Name – Last name of the primary policy holder for the health insurance plan.
c. Health Insurance Policy Number – Policy number for the health insurance plan.
d. Employer Group Name – Name of the employer group.
e. Employer Group Number – Number of the employer group.



5. Health Insurance Information
    a. Health Insurance Street Address – The claims/billing street address of the insurer, if known.
    b. Health Insurance City
    c. Health Insurance State
    d. Health Insurance Zip Code
    e. Health Insurance Phone Number
    f. Policy Start Date Input *(required)* – Date the policy number was first effective in the following format: MM/DD/YYYY
    g. Policy End Date Input – If providing historical insurance information, the date the policy ended.
        i. If the policy is **still active**, leave blank.

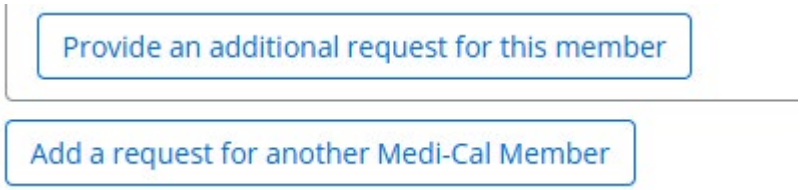


6. Comments – Add any additional comments regarding the request.



Once complete, select from the following options:

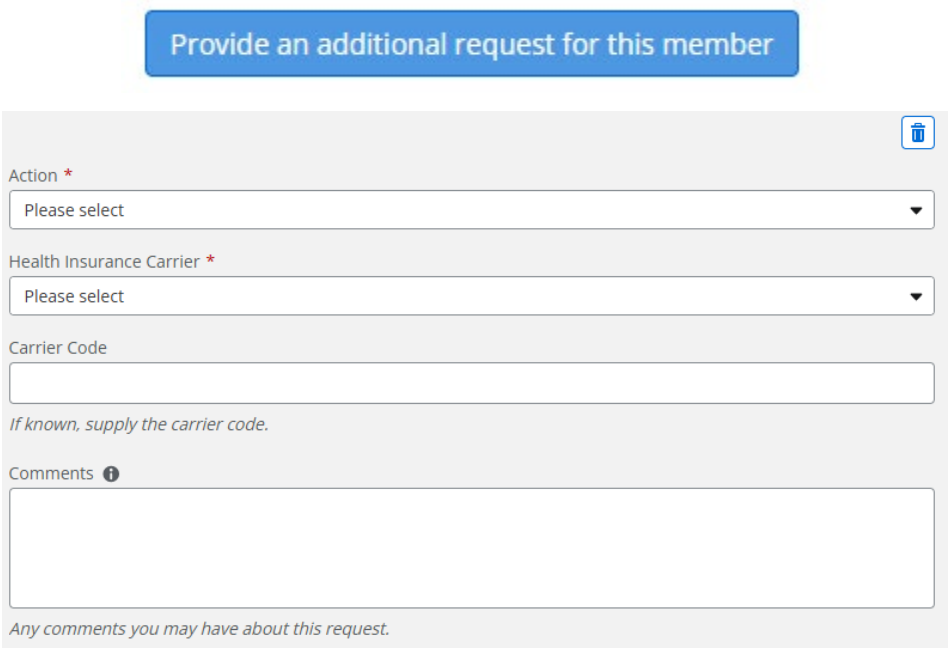
- "Provide an additional request for this member", and/or
- "Add a request for another Medi-Cal member", and/or



- "Next" – To move forward with the submission
- "Previous" – To go to the previous screen.

New Feature: Provide Additional Requests

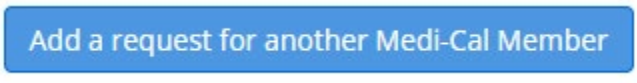
If the "Provide an additional request for this member" is selected, a new section will appear allowing the user to request an additional removal or addition for the same member.

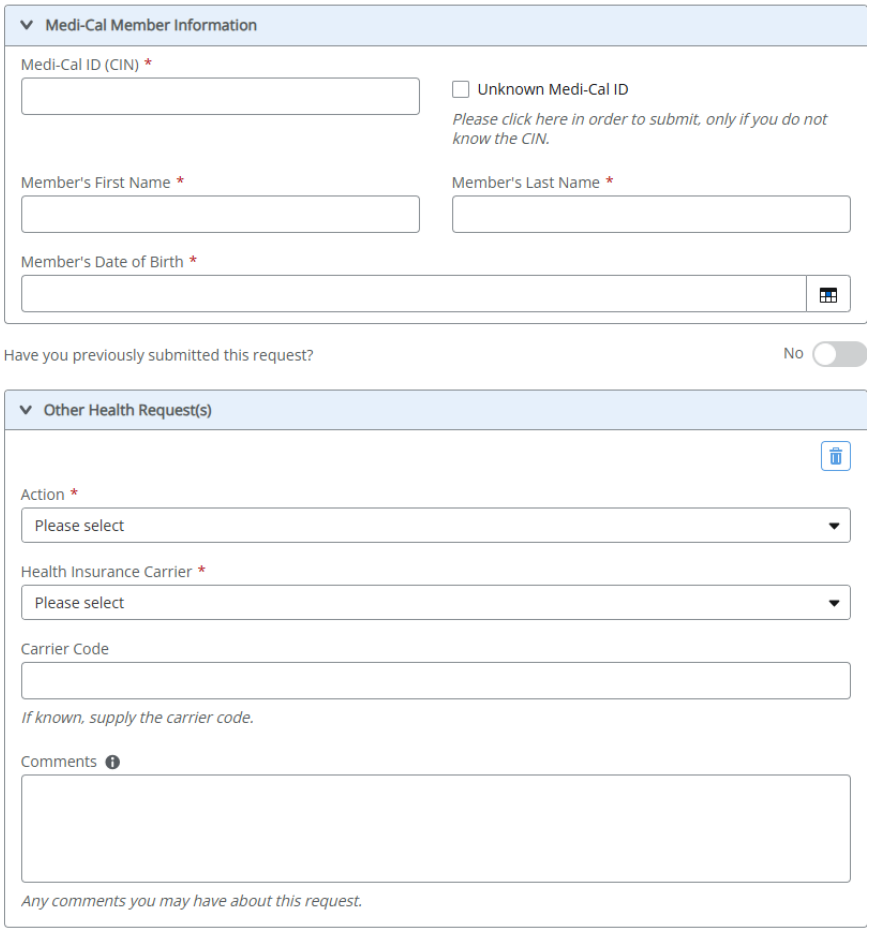


- Requests for additions and removals can be submitted at the same time for the same member.
- If an additional request is generated in error, click the trash can icon to delete the additional request.

New Feature: Add a request for another Medi-Cal Member

If the "Add a request for another Medi-Cal Member" is selected, a new section will appear allowing the user to create a removal or addition request for another Medi-Cal member in the same submission.



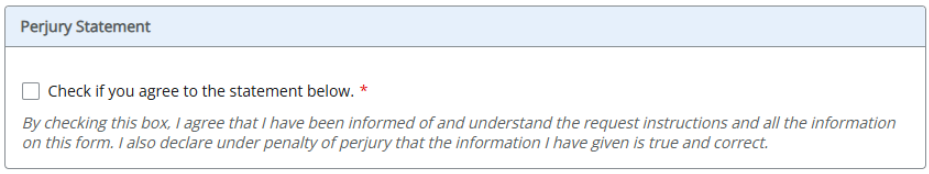


- Requests for up to **5 unique individuals** can be completed in the same submission.
- If an additional member request is generated in error, click the trash can icon to delete the additional entry.

PERJURY STATEMENT:

Complete the Perjury Statement by checking the box if you agree with the statement below:

- "By checking this box, I agree that I have been informed of and understand the request instructions and all the information on this form. I also declare under penalty of perjury that the information I have given is true and correct."



Then, press:

- "SUBMIT" to complete the submission, or
- "PREVIOUS" to return to the previous page.

NOTE: The OHC Processing Center is **UNABLE** to assist with updates or terminations for:

1. **Medi-Cal Managed Care Plan:** Contact the Medi-Cal Managed Care Division, Office of the Ombudsman at 1-888-452-8609 for assistance. This includes "59" hold requests.
2. **Medicare Removal:** OHC Processing Center can only remove Part C or D until our next federal data exchange. If your request involves removing Medicare Part A, Part B, or to permanently remove Medicare coverage, please contact your service representative at the Social Security Administration or Centers for Medicare & Medicaid Services (CMS).
3. **Parolee or Incarcerated Juvenile (OHC codes "G" or "I"):** Contact your county eligibility worker for assistance. County workers refer to ACWDL 22-26 (https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/22-26.pdf).
4. **Medi-Cal for Families Program (previously known as Healthy Families Program):** Please contact Medi-Cal for Families Program at 800-880-5305 for assistance.
5. **Medi-Cal Benefits:** This includes any Medi-Cal eligibility issues. Contact county eligibility worker.