STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 657-2941

September 8, 1995

TO: All County Welfare Directors
All County Medi-Cal Program Specialists/Liaisons

Letter No. 95-54

EXTENSION OF THE EARNED INCOME TAX CREDIT (EITC) TO AGED, BLIND, AND DISABLED (ABD) LINKED MEDI-CAL BENEFICIARIES

This All County Welfare Directors Letter is to inform counties that the EITC specified in Title 22, California Code of Regulations, Section 50543.5, is also applicable to individuals who are linked to Medi-Cal as ABD persons. Effective no later than November 1, 1995, extend the EITC exemption to ABD persons in new cases and apply this exemption to the EITC of ABD persons in continuing cases for months back through January 1, 1995 as the county becomes aware that EITC was received in any of these past months.

Direct questions or comments to Dave Rappolee of my staff at (916) 657-0163.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Section

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 657-2941

October 17, 1995

TO: All County Welfare Directors
All County Administrative Officers

Letter No.: 95-54

OTHER HEALTH COVERAGE CODING PROCEDURE CHANGE FOR HEALTH MAINTENANCE ORGANIZATION/PREPAID HEALTH PLAN EMERGENCY OUT-OF-AREA SERVICES

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) mandates that health care service plans (including Health Maintenance Organizations [HMO] and Prepaid Health Plans [PHP]) must enroll children in the absent parent's health plan regardless of whether the children reside within the health plan's service area. There is no provision in OBRA 93, however, that requires the health plan to provide routine out-of-area coverage for medical services. Typically, HMO/PHP contracts cover only emergency care provided out of the service area by nonplan providers. Faced with the question of how to ensure maximum utilization of this out-of-area coverage without jeopardizing the children's access to care, the Department of Health Services (Department) will post-pay recover ("pay and-chase") claims for all recipients residing outside the service area of a private HMO/PHP, or who must travel more than 60 miles or 60 minutes to receive care.

Normally, a Medi-Cal eligibility record of a recipient with an HMO/PHP plan is assigned the Other Health Coverage (OHC) code "K"- Kaiser, "C"- Champus, or "P"- other HMO/PHP. In the past, if the recipient had to travel more than 60 miles or 60 minutes to receive care from a plan provider, the OHC code was replaced with an "N", denoting no other coverage.

As a result of the Department's decision to post-pay recover, effective December 1, 1995, the "K", "C", or "P" codes are to be replaced with the pay-and-chase code "A" when the client reports he/she resides outside the plan's service area or must travel more than 60 minutes or 60 miles to receive care from the HMO/PHP. A Health Insurance Questionnaire (DHS 6155) must be sent to the Department, with the statement "Outside Health Plan Area" noted in question number 1, next to the insurance carrier's name.

The Department is currently developing the capability to bill the HMO/PHP for emergency out-of-area claims. Using the OHC code of "A" will facilitate the carrier billing. Providers will be advised that claims for recipients with such out-of-area coverage may be billed directly to Medi-Cal without proof of HMO/PHP denial.

If you have any questions regarding this new procedure, please call Ms. Chari Hug of the Health Insurance Section at (916) 327-0492.

Sincerely,

ORIGINAL SIGEND BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

HEALTH INSURANCE QUESTIONNAIRE

Please provide all the information requested and return this form to your eligibility worker. Use and attach a copy of your insurance card, reimbursement card, or any other aid to help you complete this questionnaire. PLEASE TYPE OR PRINT. DO NOT ABBREVIATE. Additional instructions, information, correction, and access are on the reverse. If you have any questions about completing this form or requesting Spanish translation, call (800 952 5294 (7 30 a m to 5 00 p m)

COMPLETE THIS FORM FOR ANY HEALTH INSURANCE, INCLUDING MEDICARE SUPPLEMENTS, PREPAID HEALTH PLANS, HEALTH MAINTENANCE ORGANIZATIONS, OR CHAMPUS. HAVING PRIVATE HEALTH INSURANCE DOES NOT AFFECT YOUR MEDI-CAL ELIGIBILITY. HOWEVER, FAILURE TO REPORT OTHER HEALTH INSURANCE MAY BE CAUSE FOR TERMINATION OF YOUR MEDI-CAL ELIGIBILITY.

Case Name Case Address	FOR COUNTY USE ONLY Worker Number	STATE USE ONLY Verified By	
	Date	Date	Initials
	Worker Telephone Number	Date	Initials
Initial Intake ☐ Redetermination ☐ HIPP ☐	Optional Dist No	Scope	CC #

SECTION I: Beneficiary Information *LIST ALL PERSONS, INCLUDING UNBORNS, ON MEDI-CAL AND COVERED BY HEALTH INSURANCE POLICY*

					14-DIGIT MEDI-CAL NUMBER				
ONC	Beneficiary Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Co. Code	Aid Code	Case Number	FSU	Pers No
		— —							
		— —							
		— —							
		— —							
		— —							
		— —							

SECTION II: Health Insurance Information

1. What is the name and address of your health insurance company? Include street number, city, state, and ZIP. Do not use abbreviations.
   Name:
   Address:
   City, State, ZIP
   Do you have to obtain medical services from a specific facility or a group of providers? (PHP/HMO-PPO) ☐ Yes ☐ No
2. Where do you send your claims?
   Name:
   Address:
   City, State, ZIP
3. What is the full name, address, phone number, and SSA number of individual, employee, union member, or person to whom the insurance policy was issued?
   Name: Social Security Number:
   Address: Telephone Number: ( )
   City, State, ZIP Absent Parent? ☐ Yes ☐ No
4. What is the ID or number?
5. What are the dates of your policy? Beginning Date: Ending Date (if applicable):
   ☐ Medical coverage available through employer, but has not been applied for
6. Premium Amount: $ ☐ Monthly ☐ Quarterly ☐ Yearly
   How are premiums paid? ☐ By Insured to Insurance Carrier ☐ By Employer ☐ By Payroll Deduction
7. Give name of union, employer, group, organization, or school, address, and telephone number.
   Name: Local or Group Number:
   Address: Telephone Number: ( )
   City, State, ZIP
8. Does any covered beneficiary have an acute, chronic, or pre-existing illness that requires him/her to see a physician? ☐ Yes ☐ No
   If yes, please specify the illness:
9. Does your health insurance provide or pay for: (Check all that apply.)
   ☐ Hospital Outpatient (i.e., lab work/ physical therapy) ☐ Prescription Drugs ☐ Long Term Care/Nursing Home
   ☐ Hospital Stays ☐ Dental Care ☐ Only specific illness (i.e., cancer)
   ☐ Doctor Visits ☐ Vision Care Type of Illness
10. Is the policy a Medicare Supplement? ☐ Yes ☐ No

Remarks

"By signing this document, I hereby authorize the Department of Health Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made in my behalf, to be used in determining whether the Department will pay my private health insurance premium."

Signature of Applicant	Home Telephone	Work Telephone	Date
	( )	( )	

RETURN COMPLETED FORM TO: RECOVERY BRANCH, P.O. BOX 1287, SACRAMENTO, CA 95812-1287

Original—State Yellow—County File Pink (Extra Copy-District Attorney-Beneficiary)

DHS 6158 (10-88)