Other Health Coverage Reference Guide

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).

OHC Removal Forms

Section A:	**Section A: Submitter's Contact Information:**
1. Submitter's Information – Who is submitting the request? (i.e. Medi-Cal member, County Worker, Insurance Carrier, Health Provider, DHCS Employee, or Telephone Service Center . 2. Submitter's Name – Name of 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 submitter if discrepancies arise.	1. **Submitter's Information - select one:** 2. **Submitter's Name** 3. **Email Address** 4. **Phone Number**

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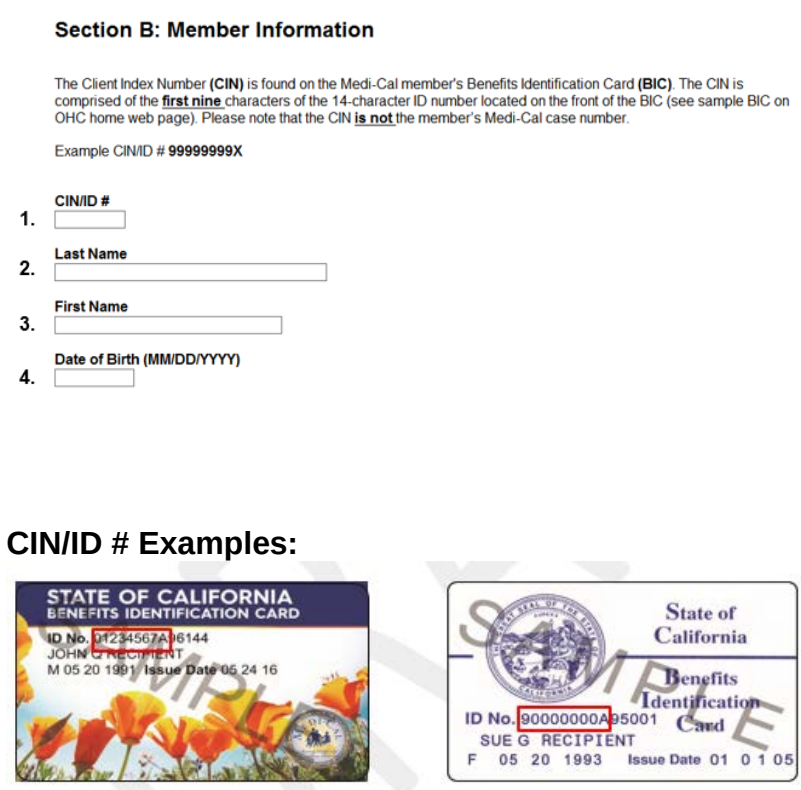
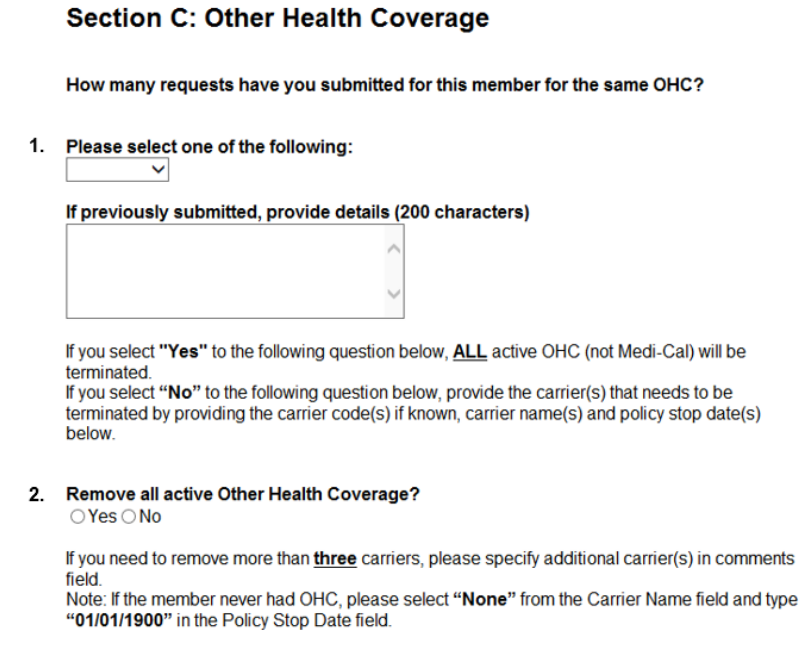
Section B:

1. CIN/ID # – 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).
2. Last Name – Last name of Medi-Cal member having OHC removed/modified.
3. First Name – First name of Medi-Cal member having OHC removed/modified.
4. Date of Birth – 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.



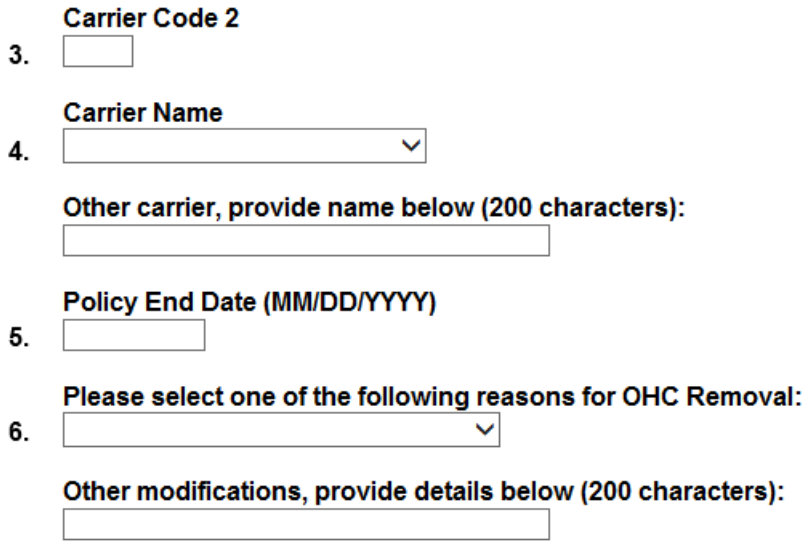
Section C:

1. Number of Requests Submitted – Select the number of times the OHC request has been submitted for the member for the specific OHC from the drop-down list. If the request has been submitted more than three times, provide details in the comment box.
2. Remove all Active OHC – Select "Yes" if you wish to remove **all active** OHC. If "No" is selected, please select the carrier name from the drop-down list and



provide the policy stop date for the OHC being requested to be removed. If carrier name is not on list, provide name in comment box.

3. Carrier Code – 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. If the "Remove all Active OHC" option is selected "Yes", **ALL** active carrier codes will be removed.
4. Carrier Name – Select the carrier name from the drop-down list for the OHC being requested to be removed. If carrier name is not on list, provide name in comment box. If the member never had OHC, please select "None" from the drop-down list.
5. Policy End Date – Provide the date the OHC policy terminated in the following format: MM/DD/YYYY. 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.
6. Reason for OHC Removal – Provide the reason why the OHC is being removed. Select one of the options from the drop-down list. If neither of the options apply, provide details in the comment box.



7. Submission Date – Provide the date the request is being submitted in the following format: MM/DD/YYYY.	**Submission Date (MM/DD/YYYY)** 7. [ ] Note: The approximate time you submitted the request will appear at the bottom of your email response. On the bottom of the email response there will be two letters followed by the time of submission. For example, if you submit a request at 9:45am the item will appear at **EX/945**. This can be used as an identification for individuals submitting multiple requests.

OHC Addition Forms

Section A: 1. Submitter's Information – Who is submitting the request? (i.e. Medi-Cal member, County Worker, Insurance Carrier, Health Provider, DHCS Employee, or Telephone Service Center . 2. Submitter's Name – Name of 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 submitter if discrepancies arise.	**Section A: Submitter's Contact Information:** 1. **Submitter's Information - select one:** [ ] 2. **Submitter's Name** [ ] 3. **Email Address** [ ] 4. **Phone Number** [ ]

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Section B:

1. CIN/ID # – 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).
2. Last Name – Last name of Medi-Cal member having OHC removed/modified.
3. First Name – First name of Medi-Cal member having OHC removed/modified.
4. Date of Birth – 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.

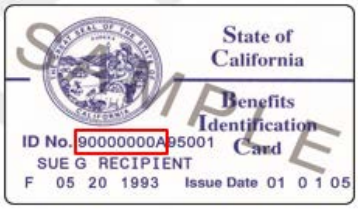
Section B: Member Information

The Client Index Number **(CIN)** is found on the Medi-Cal member's Benefits Identification Card **(BIC)**. The CIN is comprised of the **first nine** characters of the 14-character ID number located on the front of the BIC (see sample BIC on OHC home web page). Please note that the CIN **is not** the member's Medi-Cal case number.

Example CIN/ID # **99999999X**

1. **CIN/ID #**
2. **Last Name**
3. **First Name**
4. **Date of Birth (MM/DD/YYYY)**

CIN/ID # Examples:



Section C:

1. Number of Requests Submitted – Select the number of times the OHC request has been submitted for the member for the specific OHC from the drop-down list. If the request has been submitted more than three times, provide details in the comment box.
2. Carrier Code – 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

Section C: Other Health Coverage

How many requests have you submitted for this member for the same OHC?

1. **Please select one of the following:**

If previously submitted, please provide details.

If you need to add more than **one** commercial insurance policy, please use an additional form. If you do not know the carrier code, you **must provide both** the name and billing address to allow appropriate identification of the private health insurance plan.

2. **Carrier Code (if known)**

(i.e. A000). The carrier code specifies which OHC is to be added. If more than more than **one** commercial insurance policy needs to be added, please use an additional form.

3. Carrier Name – Select the carrier name from the drop-down list for the OHC being requested to be added. If carrier name is not on list, provide name in comment box.
4. Carrier Phone Number – Provide a phone number at which the carrier can be contacted.
5. Plan Type – Select the plan type of the OHC being added from the drop-down list.
6. Carrier Billing Address – Provide the address to which claims are submitted to the carrier for payment.
7. Policy Holder Last Name – Last name of the primary policy holder for the health insurance plan.
8. Policy Holder First Name – First name of the primary policy holder for the health insurance plan.
9. Health Insurance Policy Number – Policy number for the health insurance plan.
10. Policy Start Date – Date the policy number was first effective in the following format: MM/DD/YYYY.
11. Employer Group Name – Name of the employer group.

12. Employer Group Number – Number of the employer group. 13. Submission Date – Provide the date the request is being submitted in the following format: MM/DD/YYYY.