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INSURANCE ELIGIBILITY INSTRUCTIONS

Overview: A guide to conduct an eligibility for a non-traditional Medicare patient — meaning a patient that has private insurance, commercial insurance, Medicaid, workers comp, waivers, VA, etc.

Step 1

Call the insurance company and ask if the patient is eligible for home health service and if their policy is effective.

Step 2

Find out what type of insurance this is.

- Is it a Medicare Advantage/HMO?
  If yes, then you must follow Medicare guidelines.
- Is this a straight commercial insurance or any insurance not related to Medicare?
  If yes, then you do not have to follow Medicare guidelines.

Step 3

Ask the insurance company if the patient policy has out of network benefits.

Note: This is really important if you get a referral from a doctor's office or hospital that is Blue Cross, UHC, Anthem, etc., you don't want to say no because you are not contracted. A lot of agencies don't accept patients if they are not contracted. You shouldn't do that. You may be able to provide services to the patient. You should do eligibility first.

- If yes, they have out of network benefits, move on to Step 4.
  Ask the rep for a fax number so you can fax them your W-9 IRS form. You only have to do this if you have never billed before. They need to have you on file or you will not be paid.
- If no, they do not have out of network benefits, then you cannot accept the patient. Have them transfer you to the enrollment dept. and see if you can get contract or single case agreement.
  Note: About 80% of MCR Advantage Plans do not require you to be in network, so there is a good chance you will be able to accept these patients.

Step 4

Ask if authorizations are required?

- If no, move on to Step 5.
- If yes, you need to go through processes to get authorizations before seeing the patient.
  Note: About 70% of MCR Advantage Plans do not need authorization.

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Step 5

Verify the patient's financial responsibilities.

Ask about:

- Current deductible status and remaining balance
- Required copays
- Any other patient financial obligations

Important:

- Unmet deductibles will be deducted from your claim
- Document all financial obligations on consent forms
- Patient must understand their responsibilities before committing to your agency
- If collecting deductibles, secure payment upfront (credit card or check preferred) as post-service collection can be challenging
- Agency discretion: Many agencies waive reasonable deductibles/copays

On the next page, we have included a form that has all of the questions from above, and can be used when calling an insurance company to perform an eligibility check.

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INSURANCE VERIFICATION FORM

Patient Name: _____

DOB: _____

Address: _____

Tel: _____

City: _____

State: _____ Zip: _____

Insurance Company: _____

Tel: _____

ID#: _____

Billing Address: _____

State: _____

Payer ID: _____
(for elec. claim submissions)

Is Insurance: ☐ Self ☐ Other Insured

If Other Insured, what is relationship to the patient? _____

What is the Policy Holder's ID#? _____

Effective Date of Coverage: _____ Termination Date: _____

Network Benefits: ☐ In ☐ Out

Homebound Status: ☐ Yes ☐ No ☐ N/A

Face-to-Face Required: ☐ Yes ☐ No

How do we bill you: ☐ Episodic ☐ Medicare-like ☐ PPS

Is this an: ☐ Advantage Plan ☐ Straight Commercial Ins. Plan

Cover at _____%

Deductible $_____

Met $_____

Out-of-Pocket $_____

Met $_____

Co-pay $_____
(and for therapy?)

Max Benefit $_____ –or– Visits _____
(per calendar year)

Has patient used any visits: ☐ Yes ☐ No

Name of person: _____ Ref#: _____ Date: _____

Precertification/Authorization Required: ☐ Yes ☐ No

If yes, phone number for Authorization: _____

Please transfer to authorizations/case management.

Procedure Code(s): _____

Person's Name: _____

Authorization # _____

Date Auth: _____ To: _____

Case Mgr. Name: _____

Direct Tel: _____

Documentation required via fax: ☐ Yes ☐ No

Fax #: _____