# 3. Eligibility and Benefits Determination

## 3.1 Eligibility and Benefit Verification

Providers are responsible for verifying Members' eligibility and benefits. Each time a Member presents at the office for services, Providers should:

- Verify the patient's current eligibility status
- Verify covered benefits
- Obtain necessary authorizations (if applicable)

Do not assume that eligibility is in effect because a person has a Health ID Card. Please check a form of photo identification to verify the identity of the Member. Except in an emergency situation, the Provider must verify that the Member has a benefit for the service prior to providing services.

Contact the Member Services Contact Center (MSCC) to verify the Member's eligibility and benefits. It is important to verify the availability of benefits for services before rendering the service so the Member can be informed of any potential payment responsibility. If services are provided to a Member and the service is not a benefit or the benefit has been exhausted, denied or not authorized, KP may not be obligated to pay for those services.

MSCC and Self-Service is available in the IVR System
at
(888) 576-6789
Monday - Friday from 8 A.M. to 5 P.M.
Pacific Time Zone (PT)

To verify Member eligibility, benefits or PCP assignment, speak with a Member Services representative by calling MSCC. Please provide the Member's name and MRN which is located on the Health ID card.

Please be aware KP maintains Online Affiliate, an online resource for lookup of Members' eligibility and benefits. For additional information on this option, please contact KP-NCAL-OnlineAffiliate@kp.org.

### 3.1.1 After Hours Eligibility Requests

A Member who requests medical care after normal business hours must have his/her eligibility verified during the next business day. During the interim, request that the patient complete a financial responsibility form that places payment responsibility on the patient in the event that he or she is found to be ineligible as a Member or the care provided is not a

covered benefit. A financial responsibility form is not required for provision of emergency services; however KP will not pay for emergency or other unauthorized services provided if the person is not a Member.

### 3.1.2 Benefit Coverage Determination

In addition to eligibility, Providers must confirm that the Member has coverage for the services at issue prior to providing such services to a Member, usually by requesting an authorization or receiving a referral from KP. Section 4.3 of this Provider Manual provides further details on the process for obtaining referrals and authorizations, except in cases of emergency.

## 3.2 Membership Types

The table below generally describes the different HMO membership types.

| Membership Type | Membership Defined | Covered Benefits Defined By: |
|---|---|---|
| Commercial | Members who purchase HMO coverage on an individual basis (other than Medicare)<br>Members who are covered as part of an employer group and are not Medicare-eligible | Evidence of Coverage (EOC) |
| Medicare Advantage (formerly known as Medicare + Choice)<br>(aka Senior Advantage) | Individual Medicare beneficiaries who have assigned their Medicare benefits to KP by enrolling in the KP Senior Advantage Program | Medicare, with additional benefits provided by KP as described in the EOC |
| | Employer group retirees or otherwise Medicare-eligible employees who are also Medicare beneficiaries and have assigned their Medicare benefits to KP by enrolling the KP Senior Advantage Program | Medicare, with additional benefits provided by KP as described in the EOC |
| Regular Medicare (Medicare unassigned) | Members who are eligible for, and enrolled in, Medicare and for whom Medicare is the primary payor, but who also have employer group commercial coverage, and who have not enrolled in the KP Senior Advantage nor Medicare Cost programs | Dual Coverage: Two separate plans – the primary Medicare benefits are defined by Medicare; the HMO benefits are defined by the EOC |
| State Programs (Medi-Cal, Healthy Families) | Contact the Member Services Contact Center (MSCC) for detailed information specific to your geographic area. | Contact MSCC for detailed information specific to your geographic area. |

## 3.3 Benefit Exclusions and Limitations

KP benefit plans may be subject to limitations and exclusions. Before rendering services, it is important to contact MSCC to obtain information on, and verify the availability of, Member benefits for services so the Member can be informed of any potential payment responsibility.

If services are provided to a Member and the service is not a benefit, the benefit has been exhausted, denied or was not authorized, KP will not be obligated to pay for those services, except to the extent required by law.

## 3.4 Drug Benefits

The drug benefits vary based on the benefit plan. To verify if a Member has a drug benefit, please contact MSCC.