3. Eligibility and Benefits Determination

3.1 Eligibility and Benefit Verification

Providers are responsible for verifying a Member's 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. The effective date of eligibility varies according to the terms of the contract between the Plan Sponsor and KPIC. Therefore, you must verify that the Member has a benefit for the service prior to providing services.

Certain services require prior authorization. Section 4 of this Provider Manual further details which services require authorization and the process for obtaining referrals and authorizations.

Contact Self-Funded Customer Service at **(800) 663-1771**, or use one of the methods detailed below to verify a 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 you provide services to a Member and the service is not a benefit or the benefit has been exhausted, denied or not authorized, the Plan Sponsor will not be obligated to pay for those services.

Option	Description
#1	Self-Funded Website http://provider.kphealthservices.com 24 hours / 7 days a week To verify Member eligibility, benefit, and claims information. 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 our Provider Relations Department
#2	Self-Funded Customer Service **(800) 663-1771** Monday–Friday from 7 A.M. to 9 P.M. Eastern Time Zone (ET) (until 6 P.M. Pacific Time)

Option	Description
	To speak with a customer service representative to verify Member eligibility, benefits or PCP assignment. Please provide the Member's name and MRN, inclusive of suffix, which is located on the Health ID Card.

3.2 Benefit Exclusions and Limitations

Self-Funded benefit plans may be subject to limitations and exclusions. Before rendering services, it is important to contact Self-Funded Customer Service 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 you provide services to a Member and the service is not a benefit, the benefit has been exhausted, denied or was not authorized, the Plan Sponsor will not be obligated to pay for those services.

3.3 Drug Benefits

The drug benefits may vary based on the benefit plan. To verify a Member's drug benefit or for general questions, please contact the Self-Funded Customer Service.

3.4 Retroactive Eligibility Changes

If you received payment on a claim that is impacted by a retroactive eligibility change, a claims adjustment will be made. The reason for the claims adjustment will be reflected on the remittance advice.

If you provide services to a Member and the service is not a benefit, or the benefit has been exhausted, denied or not authorized, the Plan Sponsor may not be obligated to pay for those services.