# DMAP Worker Guide III

## Medical Care Identification



May 2008

# Medical Care Identification

## Introduction

The Medical Care Identification (ID) is a letter-sized sheet of paper that is mailed to each qualifying household once a month. When certain changes are made to a case, such as a change in the household or a change in managed care enrollment, the system automatically issues a new Medical ID. The system does not automatically send out a new Medical ID for every action taken on a case. ELGH will show the last three dates a Medical ID was sent.

For clients enrolled in a DMAP contracted managed care organization (MCO), the first Medical ID they receive may not show their MCO. Until their MCO choice is listed on the Medical ID, clients may go to any medical provider who will accept their Medical ID on a fee-for-service or open card basis. After the MCO is listed on the Medical ID, clients must get their care through their selected MCO.

The Medical ID also shows the benefit package for every eligible member in the household (fields 9a and 9b) and copayment requirements (fields 7a and 7b). Clients have been instructed to contact their worker if information on the Medical ID is incorrect or if information changes (examples include: address change, someone becomes pregnant, or someone leaves the household). Workers are then responsible for entering changes into the computer system.

## Issuing a Replacement Medical Care ID

Sometimes workers may need to issue a replacement Medical ID. Replacements may be necessary if a client moves or if their card has been lost or destroyed. Workers may order replacement Medical IDs using the ELGH screen. Replacement cards are mailed the next working day to the client's mailing address and are intended to replace their original Medical ID. Replacements are only issued for the current month and cannot be requested for prior or future months.

## Issuing a Temporary Medical Care ID

In some situations the client may not have time to wait for a replacement Medical ID to be mailed because they have a medical appointment or need a prescription filled. When this occurs the worker can create a temporary Medical ID through the MID1 screen, or if the DHS system is unavailable, the worker can complete a handwritten, temporary Medical ID (DMAP 1086).

Temporary IDs can be handed to the client or faxed directly to a client's medical provider or pharmacy. If the client does not have an immediate need, DMAP prefers that you order a replacement card on ELGH.

Examples of each type of ID follow, showing front and back of the forms.

(1) (2) (3)

## DMAP Medical Care Identification (ID)

(4) Branch Name  Division (5) Worker (6) Phone

| (7a) Copay Requirements |
|---|
| **A** $3 for outpatient services not paid for by your Plan (listed in 8a) |
| **B** $0 - $3 for drugs not paid for by your Medical Plan (listed in 8a) |

| (8a) Managed Care/TPR |
|---|
| **A** |
| **B** |
| **C** |
| **D** |
| **E** |
| **F** |
| **G** |
| **H** |
| **I** |

| (9a) Benefit Package | |
|---|---|
| **A – OHP Plus** | **D – OHP with limited drug** |
| **B – OHP Standard** | **E – CAWEM Emergency Medical** |
| **C – QMB** | |

All non-emergency care must be approved by applicable Managed Care/TPR shown in field 8a. See DMAP General Rules OAR 410-120-1210 for specific benefit package limitations. All DMAP administrative rules can be found on the DMAP Web site at: www.oregon.gov/DHS/healthplan/

| (10) Name of Eligible Person(s) | (11) Recipient ID | (12) Date of Birth | (13) Dates of Coverage | (7b) Copay Req | (8b) ManagedCare/TPR | (9b) Benefit Package |
|---|---|---|---|---|---|---|
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**IMPORTANT:**

(14)

- **This is your new DMAP Medical Care ID. Issued on:**
- **Show this ID to all providers, even if you have a Managed Care Plan card.**
- **Not valid outside the United States or US Territories.**

## Clients

If the information on the front is wrong, call your branch office right away (field 6).

Unless it is a true emergency, call your provider before you use the emergency room.

You may have to pay for the service if you use a provider who is not an Oregon Medicaid provider or with your Managed Care Plan.

If you need help making health care appointments or getting a ride, call your branch office (field 6).

For questions about:

- Eligibility – call your worker (field 6).
- Medical benefits – call your Managed Care Plan (field 8a) or provider.

Call the Client Services Unit (CSU) at 1-800-273-0557 if:

- You have concerns about access, quality, or limitations on your health care, or
- You receive a medical bill.

## Your DMAP Medical Care ID shows:

⑤ Your worker's code.

⑥ Your worker's phone number.

⑦a Shows possible copay requirements. For a more detailed description of these copayments, see your OHP Client Handbook or call your worker to get a copy.

⑦b Letters in this space refer to the copay requirements (listed in field 7a) for each family member. If this space shows "NO COPAYS," a copay is not required for the time period listed in field 13.

⑧a Name and phone number of your Managed Care Plans, private insurance, or DMAP pharmacy.

⑧b Letters in this space refer to information listed in field 8a and show where each family member must receive health care services. If this space is blank, the family member can get health care services during the time period listed in field 13 on a fee-for-service basis. This means you can see any provider who will take your DMAP Medical Care ID.

⑨b Letters in this space refer to benefit packages (listed in field 9a) and show which package applies to each family member.

⑪ Health care providers use the recipient ID number to bill DMAP.

⑬ Dates show when family members are:

- Required to make a copayment (see field 7b).
- Covered on a fee-for-service basis or by Managed Care Plans, private insurance, or DMAP pharmacy (see field 8b).

⑭ Message Box. A monthly message from the Department of Human Services.

DMAP Client materials can be found on the DMAP Web site at: www.oregon.gov/DHS/healthplan/

## Providers

DMAP will only pay for services according to DMAP's administrative rules and guidelines.

DMAP will only make payment to enrolled providers.

All DMAP administrative rules, guidelines and applications to become an enrolled DMAP provider can be found on the DMAP Web site at: www.oregon.gov/DHS/healthplan/

**Remember:**

- Clients must be eligible on the date of service.
- Bill all third party resources first.
- Prior authorization is required for all non-emergency care if provider is beyond 75 miles from Oregon. For out-of-state billing information, call the client's Managed Care/TPR (field 8a). If the client doesn't have Managed Care/TPR, call 503-945-6522.

**Providers only:** If you have questions about eligibility, call AIS at 1-800-522-2508. For billing questions, call DMAP Provider Services toll-free at 1-800-336-6016.

DHS Oregon Department of Human Services

# DMAP Temporary Medical Care Identification (ID)

- Show this ID to all providers at the time of service, even if you have a Managed Care Plan card.
- Not valid outside the United States or US Territories.

**1 This identification is valid for services provided**

From _____ Thru _____ .

**Provider:** The persons named below are eligible to receive medical assistance through the Department of Human Services. All insurance and other medical resources must be billed prior to billing the Division of Medical Assistance Programs (DMAP). Some services must be prior authorized. If in doubt about services covered, prior authorization or other policy, please refer to the DMAP General Rules and provider guidelines or call the branch office listed below.

**Important Note:** To insure prompt payment processing, please delay submission of claims on these clients for two weeks following date of services so that eligibility can be recorded on the computer.

**2a Managed Care/TPR**

A

B

C

D

E

F

G

**3a Copay Requirements**

| | |
|---|---|
| **A** $3 for outpatient services not paid for by your Plan (listed in 2b) | **B** $2 Generic/$3 Brand – for drugs not paid for by your Medical Plan (listed in 2b) |

**4a Benefit Package**

| | |
|---|---|
| A – OHP Plus | D – OHP with limited drug |
| B – OHP Standard | E – CAWEM Emergency Medical |
| C – QMB | |

All non-emergency care must be approved by applicable Managed Care/TPR shown in field 2a. See DMAP General Rules OAR 410-120-1210 for specific benefit package limitations. All DMAP administrative rules can be found on the DMAP Web site at: www.oregon.gov/DHS/healthplan/

| 5 Name of Eligible Person(s) | 6 Recipient ID | 7 Date of Birth | 3b Copay Req | 2b ManagedCare/TPR | 4b Benefit Package |
|---|---|---|---|---|---|
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8. Branch Office Name and Address

9. Phone Number

10. Authorized Signature

11. Date

*Distribution:* White - Client Copy; Canary - Branch Copy

## Instructions for Completing the Temporary Medical Care ID (DMAP 1086)

1. Valid Dates – Enter the days this identification is valid.

2. Managed Care/TPR
    a) Enter all available medical resources for the case. Enter only one resource per letter. This includes DMAP contracted plans, private insurance, primary case managers, and pharmacies.
    b) Enter the appropriate Managed Care/TPR code letter from the choices listed in field 2a.

3. Copay Requirements
    a) Shows possible copay requirements.
    b) For clients who are required to pay copayments, enter “AB.” For all other clients, enter “NO COPAYS.”

4. Benefit Packages
    a) Shows the available benefit packages.
    b) Enter the appropriate benefit package code letter from the codes listed.

5. Name of Eligible Person(s) – Enter the names of the eligible clients.

6. Recipient ID – Enter the client’s prime number; not case number.

7. Date of Birth – Enter the date of birth for each client listed.

8. Branch Office Name and Address – Enter the name and address of the client's branch.

9. Phone Number – Enter the branch’s phone number.

10. Authorized Signature – Signature of an authorized branch worker.

11. Date – Enter the date this ID was signed.

**Branches**

Use this form for clients with immediate medical needs, only when the MID1 screen cannot be used. Issue a replacement Medical Care ID using the ELGH screen as soon as possible after completing this form.

TEMPORARY MEDICAL CARE IDENTIFICATION
Valid for services
Provided from 01/25/2006 through 01/31/2006

Case SCD : XX####  Prog Elig : 4

Benefit Package: A-OHP PLUS B-OHP STANDARD D-OHP with LIMITED DRUG C-QUALIFIED MEDICARE BENEFICIARY (QMB) E-CAWEM EMERGENCY MEDICAL

Copay: A-OUTPATIENT B-PHARMACY

| Recip Prime ID | Ref Package Copay | | Managed Care/Private Insurance/Restrictions: Ins Comp / Ins Cov | Pol Nmbr | Grp Pol |
|---|---|---|---|---|---|
| DOE, JANE XX#### | ABC A AB | A | SAFEWAY PHARMACY / OMAP PHARMACY | | PHARMACY RESTRICTED |
| | | B | ODS COMMUNITY HEALTH INC / OMAP Dental Plan | OD01 | |
| | | C | GREATER OR BEHAV HLTH INC / OMAP Mental Health Plan | | |

Branch/DHR Div : BAKER MSO SSD
Str : 1768 AUBURN AVE
City/St/Zip : BAKER CITY, OR 97814
Wkr ID : XX
Tele BR : 541-523-5846

Authorized Signature _____ Date _____

ATTENTION PROVIDERS

OMAP will only pay for services according to OMAP's administrative rules and guidelines. OMAP will only make payment to enrolled providers.

All OMAP administrative rules, guidelines and applications to become an enrolled OMAP provider can be found on the OMAP website at: www.dhs.state.or.us./healthplan/

REMEMBER:
Clients must be eligible on the date of service. Bill all third party resources first. All non-emergency care must be approved by applicable Managed Care/TPR. See OMAP General Rules OAR 410-120-1200 for specific benefit package limitations.

Prior authorization is required for all non-emergency care if provider is beyond 75 miles from Oregon. For out-of-state billing information, call the client's Managed Care/TPR. If the client doesn't have Managed Care/TPR, call 503-945-6522.

If you have questions about eligibility, call AIS at 1-800-522-2508. For billing questions, call OMAP Provider Services toll-free at 1-800-336-6016, in Salem at (503) 378-3697. (WMMMID1C-A)

This page completes the section when making double-sided copies.