Eligibility – Getting started

Eligibility verification delivers actionable member status information. One feature of the eligibility response is that you can use the member identified in the response to create another request, such as a claim or a claim status inquiry.

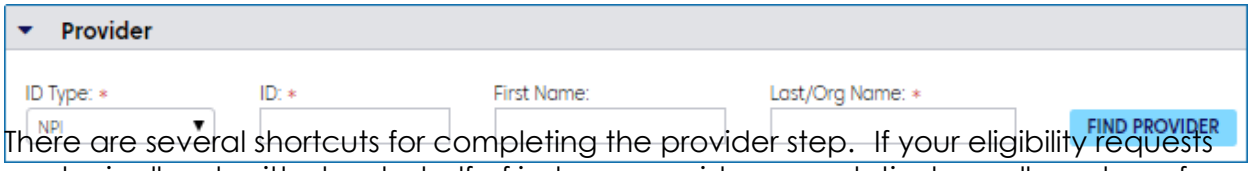
To view previously submitted eligibility records for as far back as 6 months, choose "Search Eligibility History" from the Verification menu. More information about searching your eligibility history is included at the end of this guide.

Steps to view a claim's eligibility:

Step 1 – Open the New Eligibility Request screen

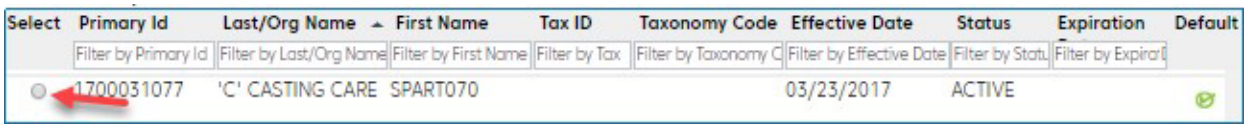
On the Verification menu, select New Eligibility Request.

Step 2 – Select the provider

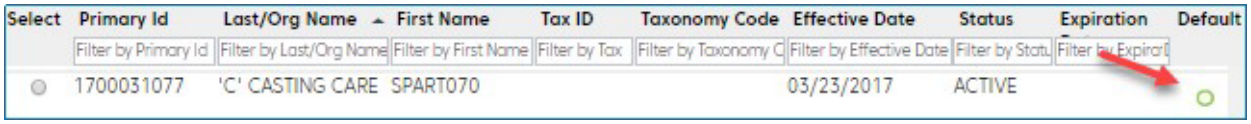


There are several shortcuts for completing the provider step. If your eligibility requests are typically submitted on behalf of just one provider or a relatively small number of providers, use **Admin**, **Provider Management** to create a list of those frequently used providers. (See ***Getting Started with Provider Administration*** for additional explanation.) You may also find that provider information you entered in the Sign-Up application when creating your account, is already available in Provider Management.

Once your frequently used providers have been listed in Provider Management, you will be able to use the Find Provider button to open the list of saved providers. Click the radio button in the Select column, on the left, next to the provider you wish to use.



You can also set a default provider by clicking **Find Provider** and then choosing the radio button found next to the desired provider in the Default column, on the right side of the table. A default provider's information will be prefilled into the provider section whenever a new eligibility inquiry is initiated.



Notes:

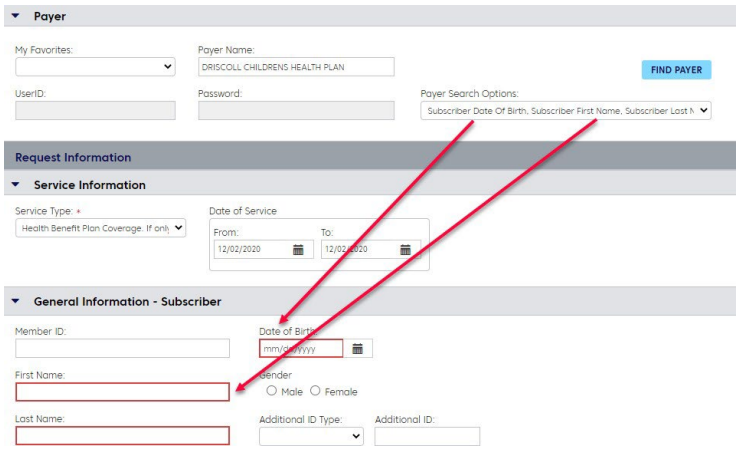
1. After opening Find Provider to choose the default provider, you must also select a provider (using the radio button on the other side of the table) to close the provider list and return to the Eligibility request.
2. In cases where multiple users are setup in the same submitter account, the provider list is shared but the preference as to which provider will be a default is not shared.
3. ConnectCenter tracks three separate types of default providers. The default provider set here will also be used in claim status and authorization/referral screens. The other two types of default providers (billing and rendering) are used only with claims. Although any given provider can be set as a default for more than just one of these default settings, selecting a provider as default for one type will not impact the default value of the other two types.

For those who determine that Find Provider is either unavailable or not suitable, an alternate short-cut involves the provider's NPI. When you Choose an "ID Type" of NPI and enter the NPI into the ID field, ConnectCenter will attempt to retrieve the matching provider record from NPPES. If found, the remainder of the required provider fields will be completed automatically.

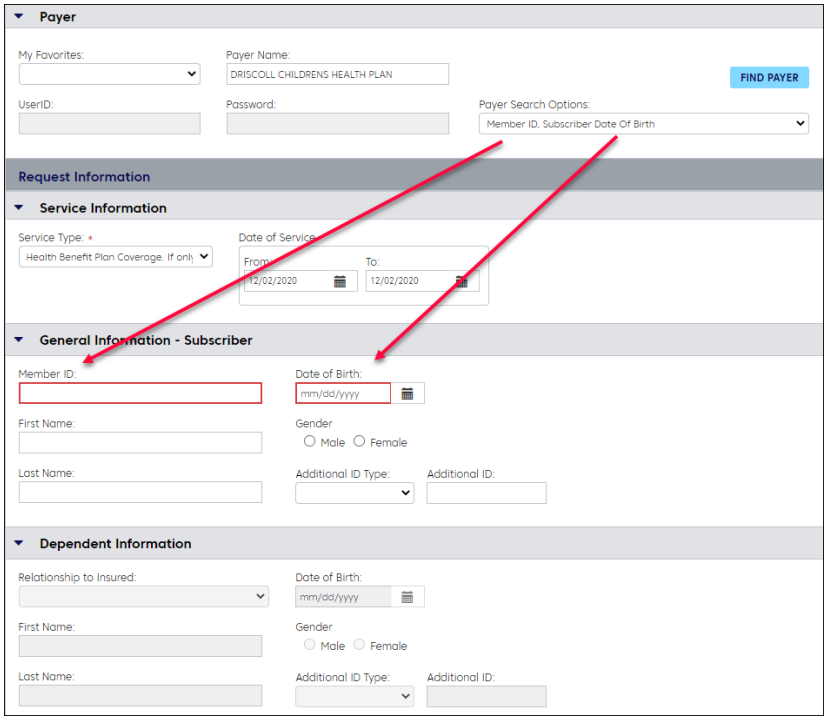
If both the NPPES inquiry and the Find Provider options prove to be not helpful, the final option is to manually key in Provider ID Type, Provider ID and Provider Name.

Payer Search Options

To accurately find your patient, a minimum set of data elements are required. Required fields related to the patient are marked with a red outline around the field. Typically, more than 1 combination of patient information can be used to find a member. To explore which alternative best matches the information you have about the member, , select from the Payer Search Options drop-down list.



Different combinations of patient demographics will be listed in the Payer Search Option drop-down list as soon as a payer has been selected. The types of member information listed will include name, ID and date of birth. The purpose of these options is to provide guidance about which combinations of member information are sufficient to retrieve eligibility data. The first option listed will be selected by default because it contains the preferred combination of member details. However, if you do not have all the information identified in that search option, or if your patient is a dependent, you can review other entries in the Payer Search Option list to evaluate whether there is a combination that better suits your needs. As you select different payer search options from the list, you may notice that the red highlighted fields in the subscriber and dependent sections will change. Because red borders indicate that a field is required, the highlighting will change to match your choice of Payer Search Options.



Step 3 – Enter Member and Service Information

In the Service, Subscriber and Dependent sections, red outlines are used to denote required fields. Note that you always have the option to include fields that are not required. Doing so can be helpful in cases where multiple members share several demographics attributes. For the Member ID field use the members 8 digit PMI.

Service Information

Service Type is a required field. ConnectCenter provides a list of service types for your selection. Health Benefit Plan Coverage is the default, as it returns the most general information. Some payers will return benefit information for a wide variety of additional service types when Health Benefit Plan Coverage is selected.

Date of Service will default to the current date. Although the default dates can be replaced with either past or future dates, some payers will not return information regarding future dates. Payers also have varying limits on how far in the past you can query.

Subscriber Information

This section allows you to identify the member who is the subject of the verification request. For most payers, several different combinations of fields can be used to retrieve eligibility information. Review the Payer Search Option instructions in Step 3 for additional information about how to choose which member information to use in your search.

Additional ID Type and ID

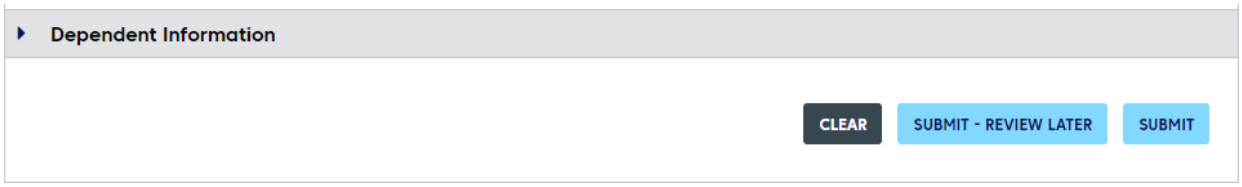
The fields for Additional ID Type and ID allow you to enter information such as the Subscriber's Group Number, Plan ID, or Social Security Number as additional identification. These values are rarely needed.

Dependent Information

Do not enter. All Hennepin Health members are their own subscriber.

Step 4 – Submit inquiry

To submit the inquiry, choose one of the two blue Submit buttons found at the very bottom of the page, on the far-right side.



Submit

Submit sends your request and displays the response immediately. All sections of the request will automatically collapse so that the new Response Information section can be more easily viewed.

Note that all inquiries sent in this fashion are automatically saved for later use, in addition to being displayed for immediate review.

Submit - Review Later

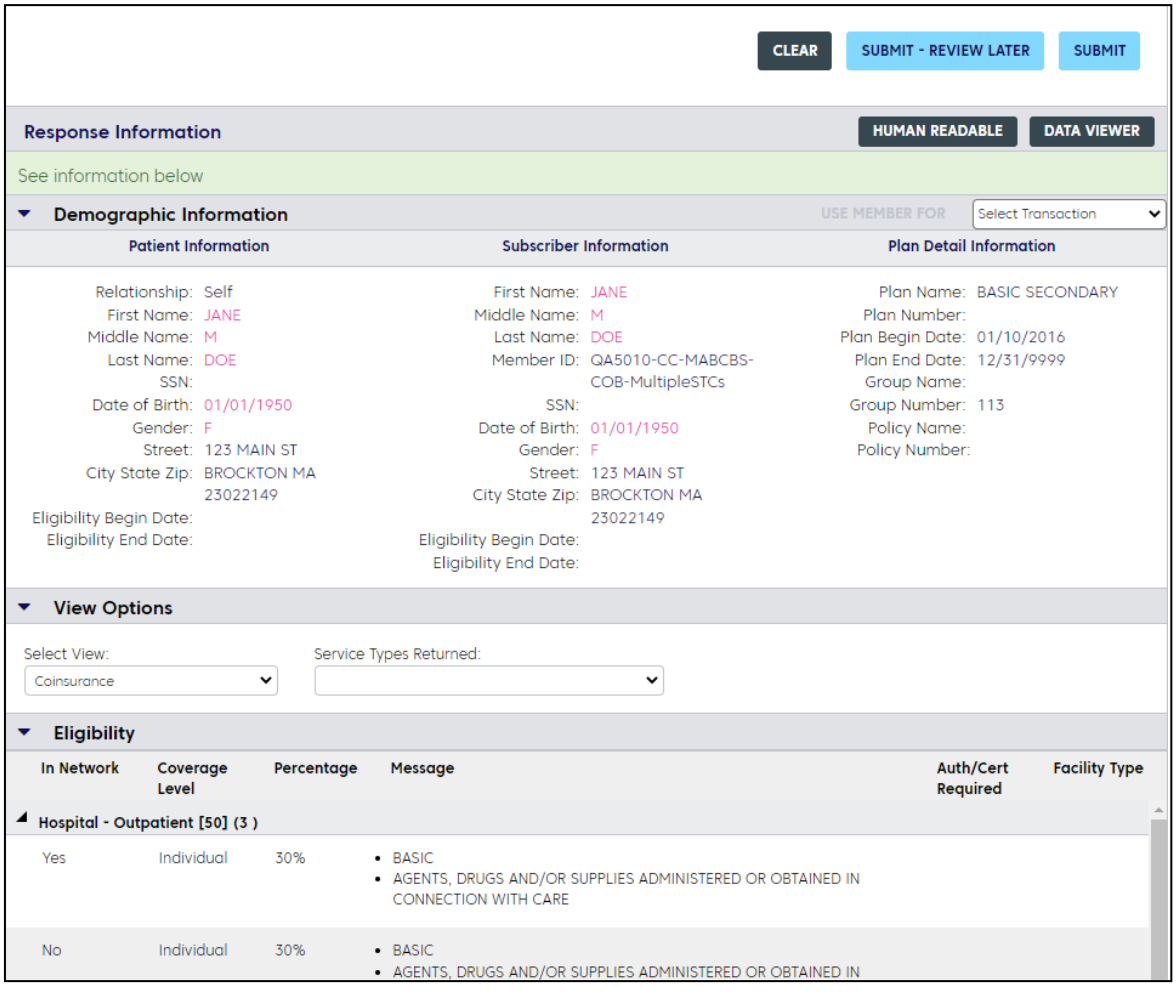
Submit - Review Later sends your request and stores the response to view later. If you chose this button, the system displays a confirmation message at the top of the eligibility form indicating that the request was successfully submitted.

Payer and provider information from the inquiry just submitted will remain on the page so that they are ready to be used with another member. However, these can be removed with the Clear button. The **Submit-Review Later** option may prove particularly helpful for those wanting to work in a heads-down data entry mode to queue up several members, before switching gears to evaluate all the results. To access saved responses later, use **Eligibility History** (Described at the end of this document).

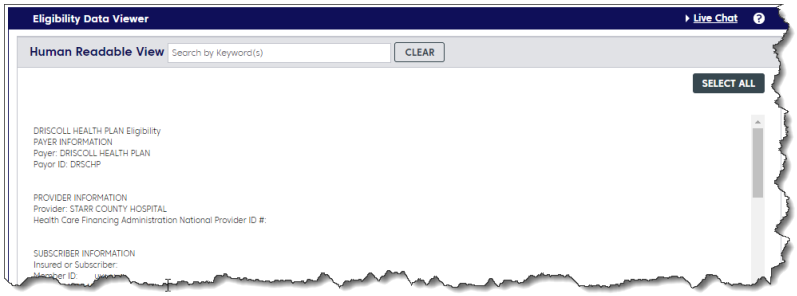
Step 5 – Eligibility response

Patient information returned by the payer is displayed beneath the Response Information title bar, just below the Submit buttons. The response begins with a color-coded bar indicating whether the member is active (green) or inactive(red) for coverage. If a system error prevents member determination, information about that error may be displayed in this area but is more likely to be added at the very top of the page.

If the eligibility response indicates that the member is active for some services but inactive for others, the service selected in the Service Type Returned field will be used to determine which status is displayed. The Service Type Returned field can be found in the View Options section of the response, directly below the Demographic Information section. View Options, and their role in configuring ConnectCenter's interactive benefit display are described in greater detail below.



Human Readable Viewer



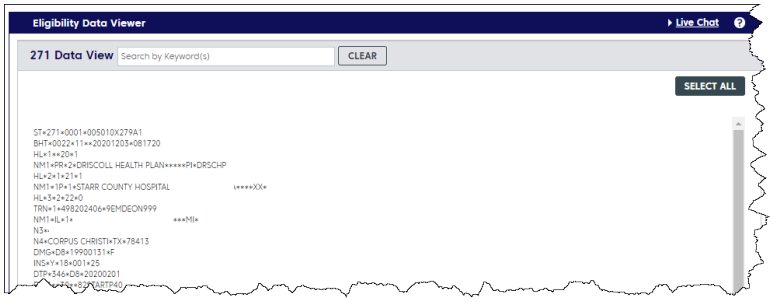
ConnectCenter displays eligibility information using interactive controls that make it easy to zoom in on the specific information you need. However, If you have a need to view the entire response at once, or if you are having difficulty finding something you expect to see in the response, use the Human Readable button. The Human Readable viewer provides access to the complete response, with simple formatting and code translations. This viewer has two convenient features:

- Use the Search by Keyword box to highlight every instance of any keyword you enter.
- Use the Select All button to quickly select the entire response. Use this with Control-C or other clipboard copy commands to copy the response from ConnectCenter to another application.

Data Viewer

The Data View works similarly to the Human Readable View. Again, the entire response is displayed. However, in this view the response will be formatted exactly as returned from the payer, encoded using the ANSI X12 guidelines for the 270/271 eligibility transaction.

This viewer will not be helpful to you unless you are familiar with the 271 syntax or have access to a 271 translator. For the benefit of those who able to make use of a 271 formatted response, the same tools offered for the Humana Readable View are available.



- Use the Search by Keyword box to highlight every instance of any keyword (or text string) you enter.
- Use the Select All button to quickly select the entire response. Use this with Control-C or other clipboard copy commands to copy the response from ConnectCenter to another application.

Note: Restricted recipient status information is viewable in the human readable and data viewer sections of a successful response.

Demographic Information

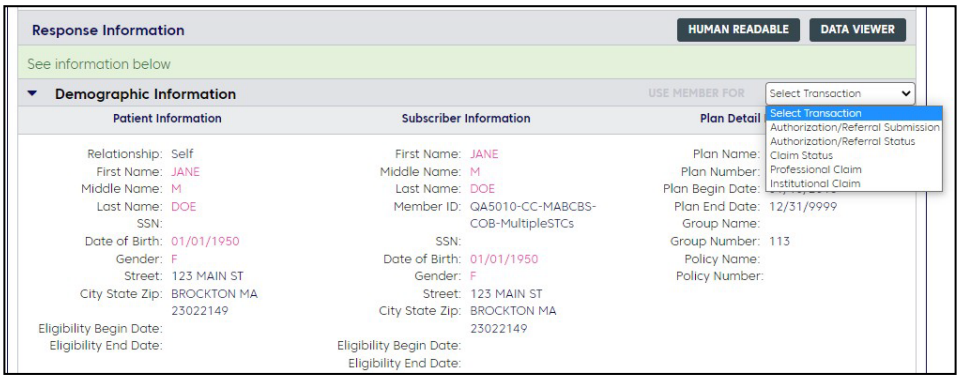
The demographic information displayed near the top of the response allows you to compare your records of the patient's demographics with payer records. Note: data displayed in red alerts you that member information entered in the eligibility request criteria conflicts with payer records. Identifying demographic differences is important in confirming that you have retrieved the intended member. Moreover, successful claims processing often depends on submitting member demographics that precisely match payer records.

The **Demographic** section also contains useful plan details such as group name, policy number, member ID and eligibility effective dates.

Use Member For - Select Transaction

Within the title bar of the Demographic section, you will find a button labeled "Use Member For" accompanied by a drop-down list reading "Select Transaction." **The only option available to Hennepin Health users is Claim Status.**

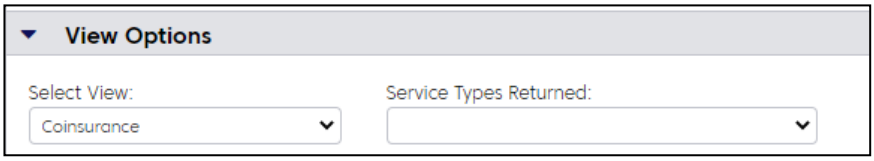
If you select a transaction from the list and click the Use Member For button, ConnectCenter will display the screen corresponding to the transaction you picked. Member, provider, and payer information from the eligibility response will be used to complete the new transaction.



Eligibility views

The interactive portion of the ConnectCenter eligibility response is displayed below the View Options section. As you review a response, you can use the **View** and **Service Types** drop-down lists, found in the View Options section, to quickly navigate between different types of benefit detail.

Service Types Returned



The Service Type Returned dropdown allows you to filter benefit information to a specific Service Type. If no Service Type is selected, the Eligibility section (described below) will contain separate sub-sections for every Service Type containing information for the selected view.

Select View

Select View allows you to select the type of benefit information to be displayed. After evaluating the initial **View**, you will be able to switch to other **View** options without needing to re-submit the request. Available views are:

- Associated Providers
- Coinsurance
- Copay
- Coordination of Benefits
- Deductible
- Limitations
- Out of Pocket Maximum

Since not all possible types of benefit information are returned for all service types, a selection made in the Select View drop down will impact the options listed in the Service Type Returned drop down list, and vice versa. For example, if Coinsurance benefits are returned for Physician Office Visits but not Hospital service types, then the selection of Coinsurance in the Select View drop down will mean that the Service Type Returned list includes Physician Office Visits but excludes Hospital. The default selection for Service Types Returned is always blank. In the previous example, if you change the Service Type Returned selection from blank to Physician Office Visit, that may well cause some of the entries previously displayed in the Selected Views drop down list to be removed. The only views that will be listed after a Service Type is

selected will be those Views that contain information about the chosen Service Type. To restore the complete list of views, reset the Service Types Returned option to show no value chosen.

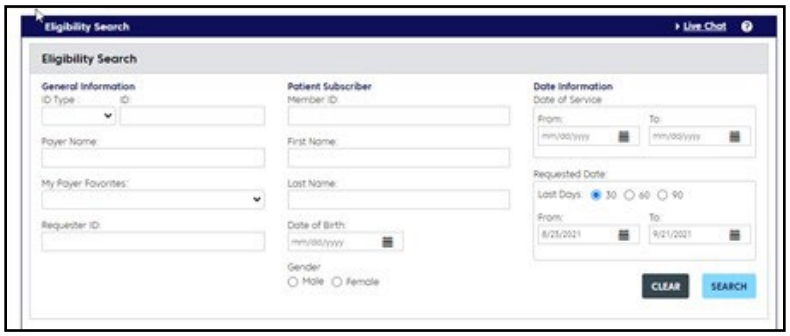
Beneath the View Options section, the Eligibility section displays the information selected in the View Options controls. Each View type will include a table with columns appropriate to the view type. The type of information (columns) that may be included for each different view is given below:

Copay View	Coinsurance View
• In Network • Coverage Level • Amount • Description • Message • Authorization/Certification Required • Facility Type	• In Network • Coverage Level • Percentage • Description • Message • Authorization/Certification Required • Facility Type
Out of Pocket View	**Deductible View**
• In Network • Coverage Level • Out of Pocket Max Amount • Time Period • Remaining • Message Deductible Total	• In Network • Coverage Level • Amount • Time Period • Remaining • Description • Message • Facility Type • Authorization/Certification Required

Limitation View - Monetary	Limitation View - Quantity
• Coverage Level • Amount • Time Period • Remaining • Message • Authorization/Certification Required	• In Network • Coverage Level • Quantity • Units • Time Period • Remaining • Message • Authorization/Certification Required
Note: Service delivery allowances and accumulators are likely to be included in one of these two Limitation Views. (ie: 12 visits per calendar year; 5 visits remaining)	
Coordination of Benefits View	**Provider View**
• Insurance Type • Coverage Level • Payer • Date • Contact Info • Message Note: if the current payer is not Medicare, Medicare information may be included in this view.	• Provider Type • Provider Name • Provider ID • Contact Info • Message Note: provider or network restriction information may be included in this view.

If the Service Type Returned list, in View Options, is left blank, and the response contains information related to the Selected View for more than one Service Type, then the Eligibility section will be divided into sub-sections with one collapsible area for each Service Type. A separate view specific table will be included in each sub-section.

Search Eligibility History

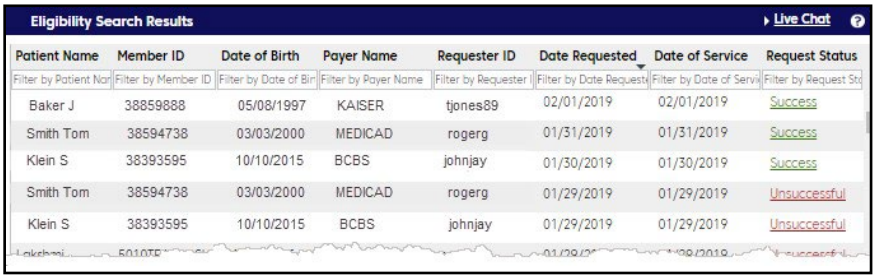


To search and view previously submitted eligibility records for as far back as 6 months, choose "Search Eligibility History" from the Verification menu.

Several search criteria fields are available to help you find benefit information for a particular member. Or you can just hit Search without entering any criteria and all eligibilities submitted within the last 30 days will be returned. Results will include both eligibility requests you created yourself as well as those created by other users associated with your account. This makes it easy to share your work with colleagues.

Results matching the search criteria will highlight the member, date that eligibility was checked and whether the initial search returned a response. Drill into successful requests by clicking "Success." The complete request and response will display.

Similarly, clicking the "Unsuccessful" link will open the eligibility request screen. However, in the unsuccessful case, error information will be displayed at the top of the screen. You may correct indicated errors and resubmit the request.



Patient Name	Member ID	Date of Birth	Payer Name	Requester ID	Date Requested	Date of Service	Request Status
Baker J	38859888	05/08/1997	KAISER	tjones89	02/01/2019	02/01/2019	Success
Smith Tom	38594738	03/03/2000	MEDICAD	rogerg	01/31/2019	01/31/2019	Success
Klein S	38393595	10/10/2015	BCBS	johnjay	01/30/2019	01/30/2019	Success
Smith Tom	38594738	03/03/2000	MEDICAD	rogerg	01/29/2019	01/29/2019	Unsuccessful
Klein S	38393595	10/10/2015	BCBS	johnjay	01/29/2019	01/29/2019	Unsuccessful

Note: that **all** eligibility transactions are stored in History without regard to whether the inquiry was originally submitted in "Submit" or "Submit - View Later" modes.