Recipient Eligibility

Introduction

Purpose

The purpose of this module is to provide an overview of the Medi-Cal recipient identification and eligibility verification process.

Module Objectives

- Review eligibility terminology
- Identify and define the Benefits Identification Card (BIC)
- Identify the functions available in the Point of Service (POS) network
- Review POS response information regarding eligibility, Medi-Service and Share of Cost (SOC) transactions

Acronyms

A list of current acronyms is in the *Appendix* section of each complete workbook.

Recipient Eligibility Terms

This module addresses internet eligibility transactions. As required by Health Insurance Portability and Accountability Act (HIPAA) electronic standards, the POS network within the internet eligibility transactions include the following terminology:

Table of Provider Manual and POS Terminology

Provider Manual Terminology	POS Network and Electronic Transaction Terminology
Date of Birth	Subscriber Birth Date
Date of Card Issue	Issue Date
Date of Service	Service Date
Eligibility Verification Number	Trace Number (Eligibility Verification Confirmation [EVC] Number)
First Name	Subscriber First Name
Last Name	Subscriber Last Name
Medi-Services	Medical Services Reservation
Provider Number	Medicaid Provider Number
Recipient	Subscriber
Recipient ID	Subscriber ID
Share of Cost (SOC)	Spend Down Amount (or SOC)
BIC ID Number	Subscriber ID
Client Identification Number (CIN)	Subscriber ID

Notes:

Benefits Identification Card

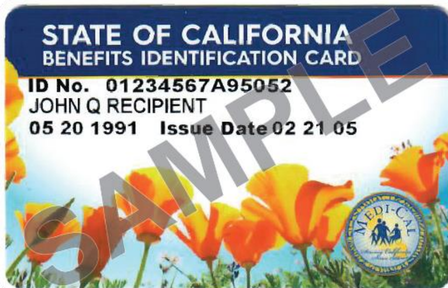
BIC Overview

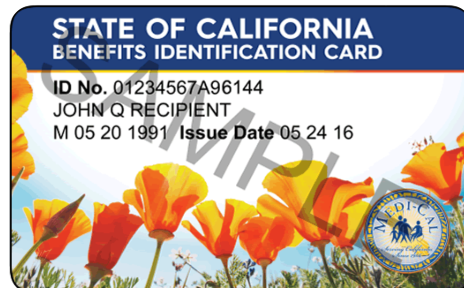
The Department of Health Care Services (DHCS) issues a plastic Benefits Identification Card (BIC) to each Medi-Cal recipient for identification purposes.

The BIC is used to access the POS network to determine a recipient's eligibility and scope of benefits. It is the provider's responsibility to verify that the person is eligible for services and is the individual to whom the card was issued prior to rendering services or goods to that individual.

The BIC is composed of a nine-character Client Identification Number (CIN), a check digit and a four-digit date that matches the date of issue. The BIC issue date is used to deactivate a card when reported as lost or stolen.

Below are three valid BIC samples. The new design, featuring the California poppy without gender, will be provided to newly eligible recipients and recipients requesting replacement cards. There are no plans to provide the new card to the entire Medi-Cal population.

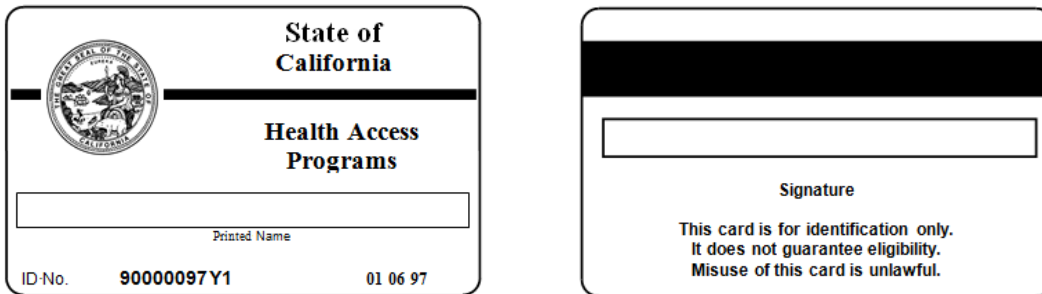




Providers should accept all BIC designs and must continue to verify eligibility.

When a provider verifies an individual is eligible to receive Medi-Cal benefits, (by this act) the provider is accepting the individual as a Medi-Cal recipient. If the provider is unwilling to accept an individual as a Medi-Cal recipient, the provider has no authority to access confidential eligibility information.

In addition to the Medi-Cal Fee-for-Services program, there is an additional program known as Health Access Program (HAP) that offers a HAP Identification Card (ID) for services that are specific to that program. Please refer to the Family PACT eligibility guidelines that can be found in the Policies, Procedures and Billing Instructions (PPBI) manual.



In addition to a provider verifying that an individual is eligible to receive Medi-Cal benefits, the provider must make a "good faith effort" to verify the recipient's identification by matching the recipient's name and signature on their HAP/BIC card against the signature on a valid California driver's license, a California ID issued by the Department of Motor Vehicles, another acceptable picture ID card or other credible identification documentation.

A mother's BIC, whether for restricted or full-scope benefits, can be used to bill full-scope medical services rendered to her newborn during the month of delivery and the following month. A separate identification number must be issued to the infant following the two-month grace period so that services can be billed separately for each recipient.

Exception

The identification requirement does not apply when a recipient is receiving emergency services, is 17 years of age or younger receiving Minor Consent services or is in a Long-Term Care (LTC) facility.

The provider must document the "good faith effort" by making a copy of the BIC and a copy of the picture identification card or other credible document of identification that was used to compare signatures.

California Children's Services (CCS) clients enrolled in the CCS program are issued a BIC. If a CCS client also has Medi-Cal, the CCS eligibility will be displayed along with the Medi-Cal eligibility.

Children eligible for CCS will be identified by aid codes unique to the CCS program.

Possession of a BIC is not proof of Medi-Cal eligibility because it is a permanent form of identification and is retained by the recipient, even when he or she is not eligible for the current month.

When using the BIC in conjunction with the Medi-Cal POS network, the following information can be identified:

- Recipient Eligibility
- Share of Cost (spend down amount)
- Other Health Coverage (OHC)/Medicare
- Aid Codes
- Medi-Cal Managed Care Plans (MCP)

BIC and temporary paper Medi-Cal ID cards must not be altered by either the recipient or provider. If a recipient presents a card that is photocopied or contains erasures, strikeouts, white-outs, type overs or any other form of alteration, providers should request that the recipient obtain an unaltered card and check other identification to ensure that the patient is the Medi-Cal recipient. Do not accept altered BIC and temporary paper Medi-Cal ID cards as proof of eligibility.

All providers are expected to use the ID number from the recipient's BIC or temporary paper Medi-Cal ID card when verifying eligibility, billing Medi-Cal, CCS or submitting Service Authorization Requests (SARs).

Reminder: Recipient Eligibility Verification

Providers are reminded that they must verify eligibility every month for each recipient who presents a plastic BIC or paper card for Immediate Need or Minor Consent. An internet eligibility response may be kept as evidence of proof of eligibility for the month for Immediate Need or Minor Consent.

For all other program eligibility verifications other than Immediate Need or Minor Consent, Providers **must** verify eligibility on the date of service even if eligibility was previously verified for the month.

Notes:

Temporary Paper Medi-Cal ID Cards

In some cases, recipients are issued temporary paper Medi-Cal ID cards from either the County Welfare Department or a Presumptive Eligibility (PE) Provider. The card contains a 14-digit ID number and is used just like a plastic BIC.

Temporary paper identification cards are issued to the following:

- Recipients new to Medi-Cal who have an immediate need for health care services
- Recipients currently eligible for Medi-Cal who have an immediate need for replacement ID card
- Eligible minors who wish to receive confidential care for services
- Recipients that are enrolled in a PE program

Sample Paper ID Card for Immediate Need and Minor Consent Recipients issued by the county.

(Actual card size = 8½ x 11 inches.)

```
*                        STATE OF CALIFORNIA                                  *
*               TEMPORARY BENEFITS IDENTIFICATION CARD                        *
*     ======================================================                  *
*     ===      FOR IDENTIFICATION PURPOSES ONLY          ===                  *
*     ===    PROVIDER:  PLEASE VERIFY ELIGIBILITY        ===                  *
*     ======================================================                  *
*  ID NO.  BICIDNUMBERXXX                   ISSUE DATE: MM/DD/YYYY            *
*                                           GOOD THRU: MM/DD/YYYY             *
*  FIRSTNAME I LASTNAME APL                                                   *
*  F     MM/DD/YYYY                                                           *
*                                                                             *
*  SIGNATURE ______________________________ _________________                 *
*                                                                             *
*      TERMVTAMCICSTRANYYYYMMDDHHMMSSDDDOPRXXXXXDISWRKR                       *
*******************************************************************************
```

Note: The ID number is the 14-character BIC ID. State law prohibits use of Social Security Numbers (SSNs) on identification cards.

The bottom line is system information that identifies the source of the card request.

Presumptive Eligibility Programs

Medi-Cal PE programs provide qualified individuals immediate, temporary Medi-Cal coverage based on the individual's self-attested preliminary information. Qualified PE providers approved by DHCS make PE determinations. The PE programs include:

- BCCTP (Breast & Cervical Cancer Treatment Program)
- CHDP (Child Health & Disability Prevention Program)
- EWC (Every Woman Counts)
- PE4PW (Presumptive Eligibility for Pregnant Women) and
- HPE (Hospital Presumptive Eligibility)

Qualified PE providers enter the PE applicant's information via Transaction Services into the Application Web Portal on the Medi-Cal Provider website *(www.medi-cal.ca.gov)* and provide PE applicants a *Single Streamlined Application* (SSApp) (CCFRM604) to apply for Medi-Cal or other health coverage.

Please refer to the specific PE program provider manual sections for detailed PE requirements.

Child Health and Disability Prevention (CHDP) Gateway

Pre-Enrollment

The CHDP Gateway allows eligible children and youth to receive up to two months of full scope Medi-Cal pre-enrollment eligibility. CHDP providers can pre-enroll eligible recipients into Medi-Cal using the CHDP Gateway internet transaction.

Infant Enrollment

The CHDP Gateway process also allows the same CHDP Gateway transaction to automatically enroll eligible infants under one year of age into Medi-Cal without their parent(s) having to complete an SSApp. Eligible infants are those whose mothers had Medi-Cal eligibility at the time of delivery and continue to reside in California. Eligible infants receive full-scope, no cost Medi-Cal until their first birthday.

Note: Refer to the *Gateway Transactions Overview* (gate trans) section of the CHDP provider manual and the CHDP Gateway Transaction user guides for additional CHDP Gateway information.

Hospital Presumptive Eligibility (HPE)

The HPE program provides qualified individuals immediate access to temporary, no-cost Medi-Cal services while individuals apply for permanent Medi-Cal coverage or other health coverage. Qualified HPE providers approved by DHCS make HPE determinations via the HPE Application Web Portal.

On the day approved for HPE, individuals receive a temporary paper BIC to sign and receive immediate, temporary HPE coverage. The HPE enrollment period ends on the last day of the following month in which the individual was approved for HPE if an SSApp was not submitted. If an Insurance Affordability Application was submitted, HPE services will continue until an eligibility determination is made (approved or denied) on the application.

Presumptive Eligibility for Pregnant Women (PE4PW)

The PE4PW program allows Qualified Providers (QPs) to grant immediate, temporary Medi-Cal coverage for specific ambulatory prenatal care and prescription drugs for conditions related to pregnancy to low-income, pregnant recipients, pending their formal Medi-Cal application.

The PE4PW enrollment period ends on the last day of the following month in which the individual was determined eligible for PE4PW if an insurance affordability application was not submitted. If an insurance affordability application was submitted, services will continue until determination is made on the insurance affordability application.

Notes:

Share of Cost (SOC)

Some Medi-Cal recipients may be required to pay a portion of their medical expenses before Medi-Cal will reimburse providers for services. This portion is known as Share of Cost (SOC) or spend down amount.

If the Medi-Cal eligibility verification system indicated a recipient has a SOC, the SOC balance must be met or obligated before a recipient is eligible for Medi-Cal benefits.

Recipient SOC amounts vary according to income and dependents and can change from month to month. This SOC amount is determined by the County Welfare Department.

CCS clients who are also Medi-Cal recipients may pay portions of their SOC during the month until their total SOC has been met. Until the SOC is met, these clients are considered CCS-only clients. Once the SOC has been met, they are considered CCS clients/Medi-Cal recipients.

Aid Codes

Aid codes help providers identify the types of services for which Medi-Cal and Public Health Program recipients are eligible. A recipient may have more than one aid code and may be eligible for multiple programs and services. The full chart of aid codes is in Part 1 of the Medi-Cal Provider Manual. The *Aid Codes Master Chart* (aid codes) was developed for use in conjunction with the Point of Service Network (POS) Providers must submit an inquiry to POS to verify a recipient’s eligibility for services.

County Codes

The Medi-Cal eligibility verification system displays a county code for the recipient. This county code identifies the county whose county department is responsible for maintaining the current county case record for Medi-Cal eligibility for a person or family. The county of responsibility may be different from the county of residence. The county of residence indicates the county the individual physically resides in.

County codes can assist in identifying if the county is a managed care county that requires recipients to enroll in a Managed Care Plan (MCP).

Managed Care Plans (MCPs)

Medi-Cal recipients enrolled in contracted Managed Care Plans (MCPs) must receive Medi-Cal benefits from plan providers and not from providers who bill through the fee-for-service program. Each MCP is unique in its billing and service procedures. Providers must contact the individual plan for billing instructions.

All recipients receive a health plan card that identifies the member's primary care physician in addition to a BIC. In most cases, the recipient presents both cards when receiving services.

Services excluded from the plan's contract require billing through the fee-for-service program, which may require prior authorization.

The *MCP: Code Directory* (mcp code dir) section in the Part 1 provider manual includes MCP information for counties that offer Medi-Cal benefits to recipients enrolled in a managed care plan. The directory lists health care plan (HCP) names, codes, addresses, telephone numbers and counties of operation.

Billing Notice

Most providers may no longer bill Medi-Cal or CCS using a recipient's SSN. Claims submitted with a recipient's SSN will be denied.

Medi-Service (Medical Services) Reservation

The POS network is also used to complete a Medi-Service reservation or reversal transaction. Medi-Cal recipients are normally allowed two Medi-Service visits per month. When providers complete a Medi-Service reservation on the POS network, the date of service and the appropriate five-digit procedure code will be required.

Medi-Services are used by Allied Health, Medical Services and Outpatient providers. A Medi-Service should be reserved before billing for the following services:

- Acupuncture
- Audiology
- Chiropractic
- Occupational Therapy
- Podiatry
- Speech Pathology

Providers should not reserve a Medi-Service unless they are certain the service will be rendered. Providers who do not provide a Medi-Service that has been reserved must reverse the reservation to allow the recipient to obtain another service.

Page updated: December 2022

To log into the Medical Services (Medi-Service) go to the Medi-Cal Provider website.

1. From the Provider drop-down menu, select **Transaction Services.**

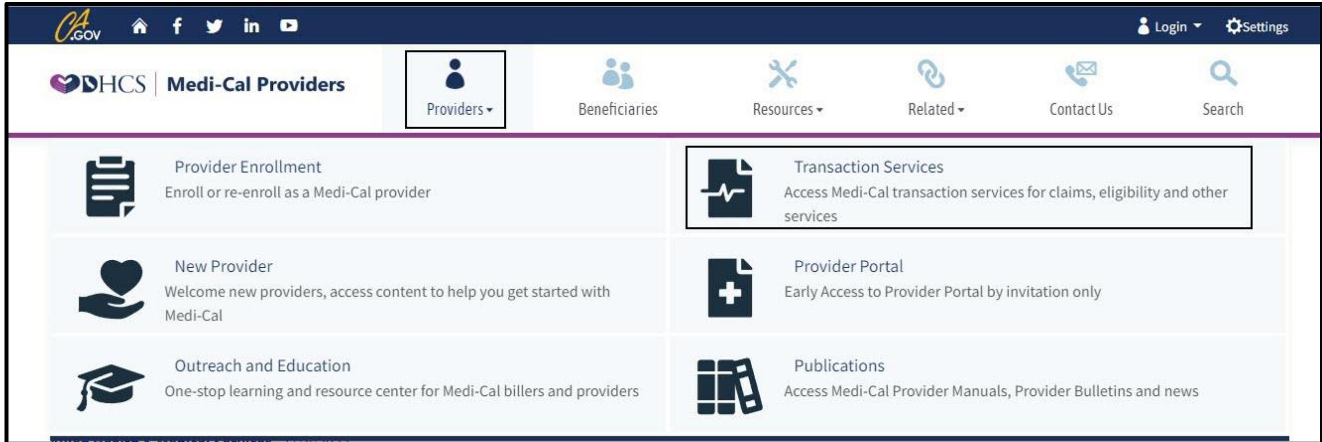


Figure 1: Medi-Cal Providers drop-down menu – Transactions Tab.

2. Login to **Transaction Services** with your **User ID** and **Password**.

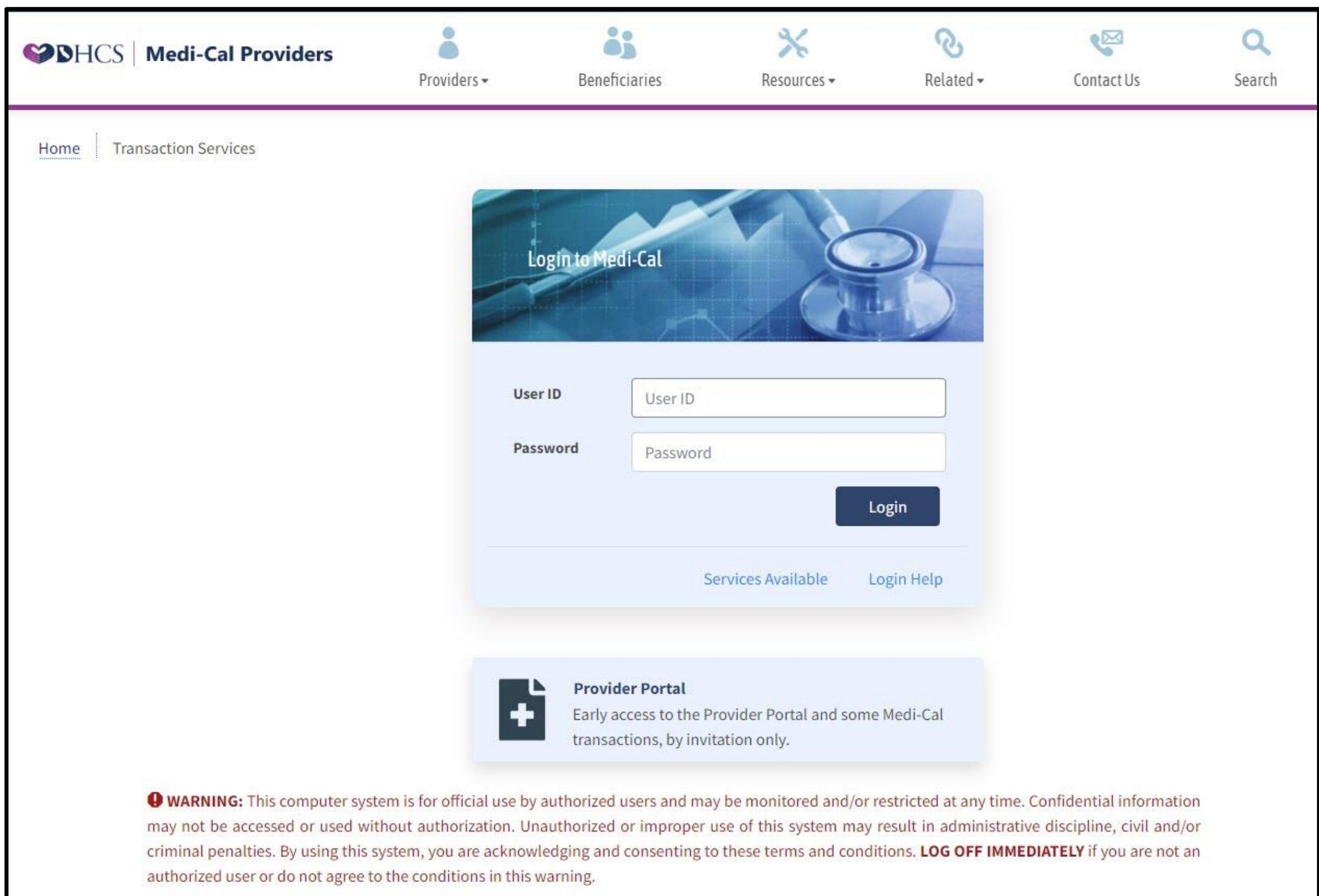


Figure 2: Transaction Services Login Page.

3. Under Claims, select **Medical Services Reservation (Medi-Services).**

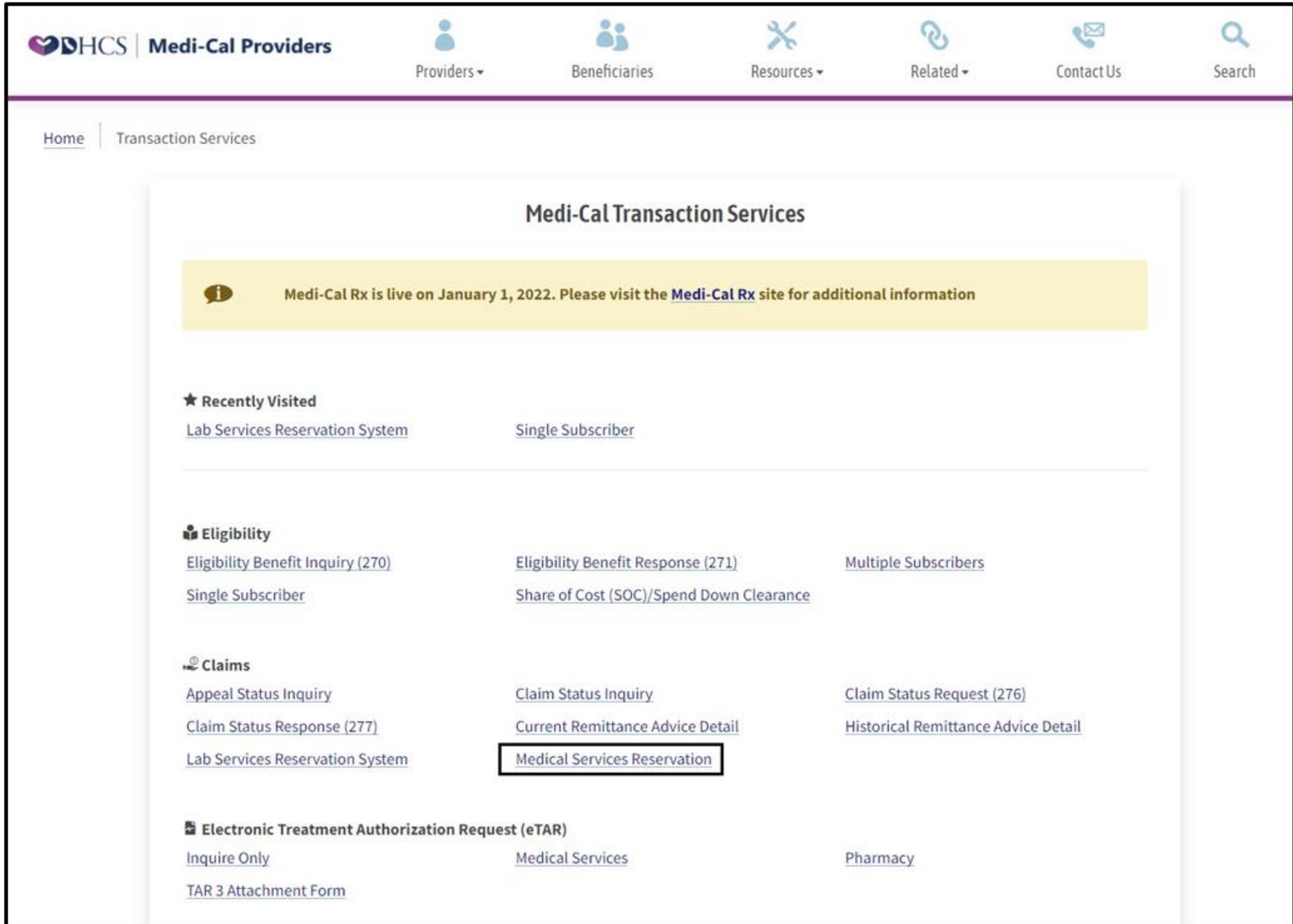


Figure 3: Medi-Cal Transactions Services – Medical Services Reservation link.

4. Fill out the reservation form and press **Submit.**

Home | Transaction Services | Medi-Services

Medical Services Reservation (Medi-Services)

* Indicates required field

Medical Services Reservation/Reversal

- Medical Services Reservation
- Medical Services Reservation Reversal

Medi-Services Detail

* Subscriber ID: Recipient ID

* Subscriber Birth Date: mm / dd / yyyy

* Issue Date: mm / dd / yyyy

* Service Date: mm / dd / yyyy

* Procedure Code: Procedure Code

SUBMIT

Figure 4: Medical Services Reservation (Medi-Services) form.

Lab Services Reservation System (LSRS)

The Lab Services Reservation System (LSRS) is an online system used to schedule beneficiary lab services. To login to the LSRS go to the Medi-Cal Provider website.

1. From the Provider drop-down menu, select **Transaction Services.**

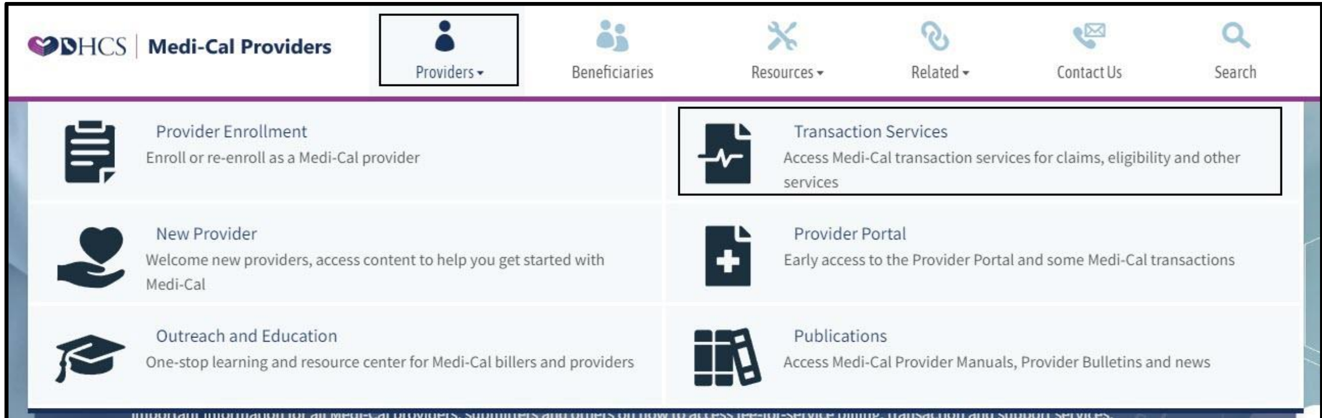


Figure 5: Medi-Cal Providers drop-down menu – Transactions Tab.

2. Login to Transaction Services with your User ID and Password.

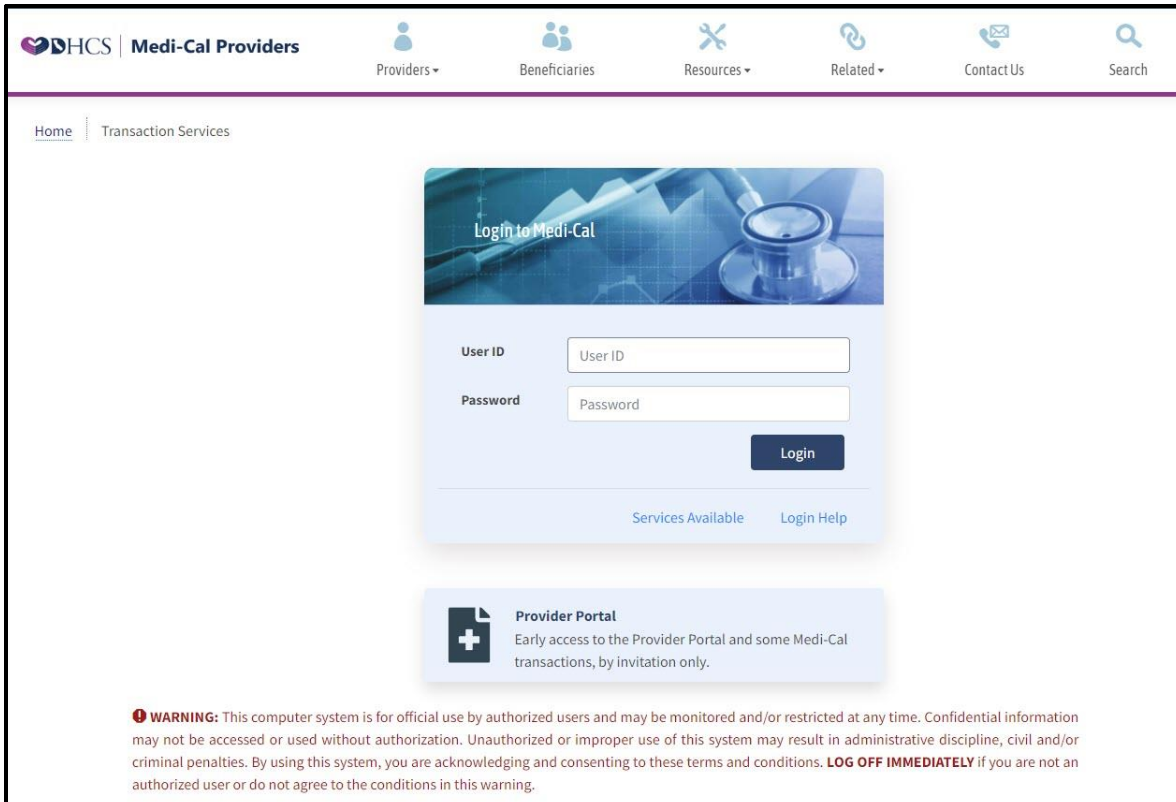


Figure 6: Transaction Services Login Page.

3. Under Claims, select **Lab Services Reservation System.**

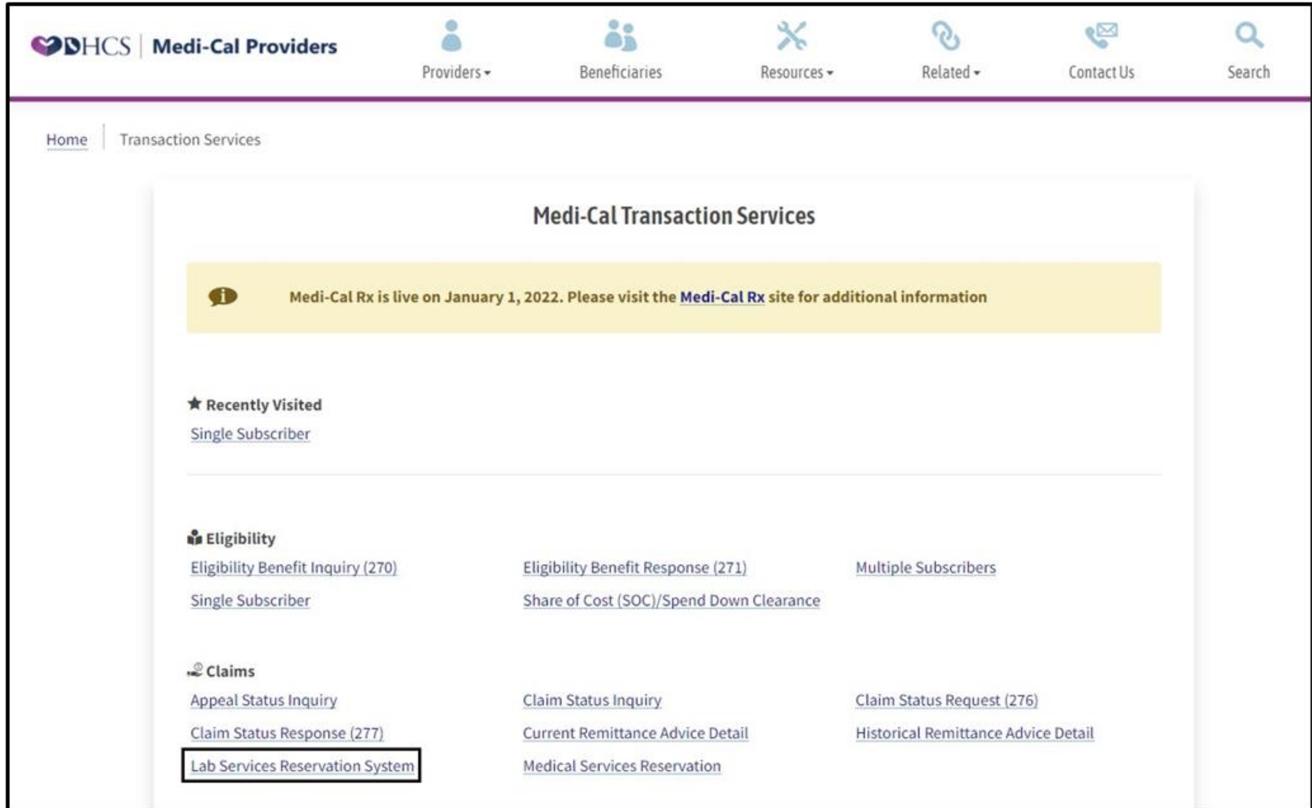


Figure 7: Medi-Cal Transactions Services page – Lab Services Reservation System link.

4. Fill out the reservation form and select **Reserve this Service.**

Figure 8: Medi Reservation Request Screen.

Knowledge Review 1

1. When a recipient provides their BIC, this means they are Medi-Cal Eligible.
   True ☐ False ☐
2. What can be identified when using the BIC to determine eligibility?
   a. Eligibility
   b. Share of Cost (SOC)
   c. Other Health Coverage (OHC)
   d. Aid Codes
   e. Managed Care Plans (MCPs)
   f. All the above
3. A provider may ask for a second form of ID to help confirm a recipient's identification.
   True ☐ False ☐

See the Appendix for the Answer Key.

POS Network

The Point of Service (POS) network allows providers to access information related to:

- Recipient eligibility
- Share of Cost (SOC)
- Scope of benefits/services
- Other Health Coverage (OHC)
- Medicare
- Medi-Cal Managed Care Plans (MCP)
- Medi-Services

POS Network Access

The POS network is accessed using any one of following methods:

- Internet (Medi-Cal Provider website)
- Third Party Software (contact CMC Help Desk at 1-800-541-5555)
- Automated Eligibility Verification System (AEVS) (1-800-456-2387)

Required information for checking recipient eligibility:

- Subscriber ID number
- Subscriber Date of Birth (DOB)
- Issue date
- Date of Service (DOS)

Notes:

Internet Eligibility Verification (Medi-Cal Provider Website) Utilizing Transaction Services

Requirements

- Medi-Cal POS Network/Internet Agreement form
- Medi-Cal Provider Identification Number (User ID) and a PIN

Internet Eligibility Verification Features

- Free of charge to all active providers
- Ability to print screen display for a recipient's file
- Capable of batch sending (defined as "single or a batch of up to 99 records")
- Located on the Medi-Cal Provider website

Providers must complete the Medi-Cal Point of Service (POS) Network/Internet Agreement form to be able to access **Transaction Services**.

To complete the POS Network/Internet Agreement form:

1. From the Medi-Cal Provider website navigate to **Resources** and select **References.**

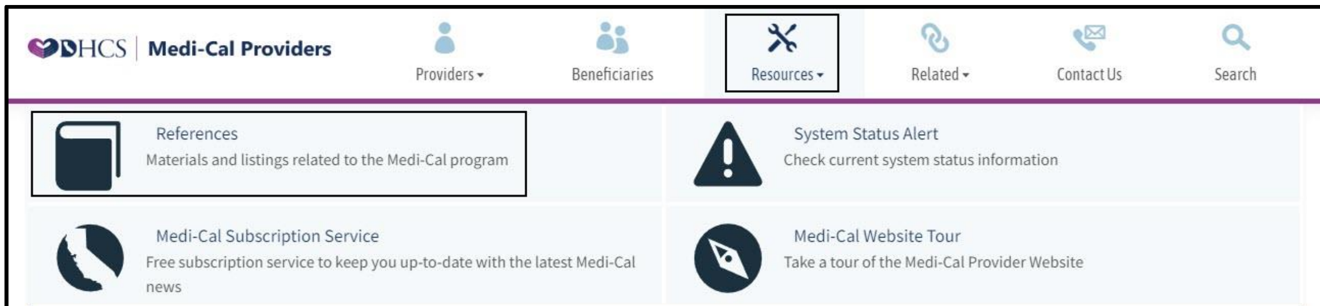


Figure 9: Resources drop down menu – **References** Tab.

2. From the Resources page, navigate to the Billing section and under Forms select **Billing (CMC, EFT, Hardcopy and POS)**.

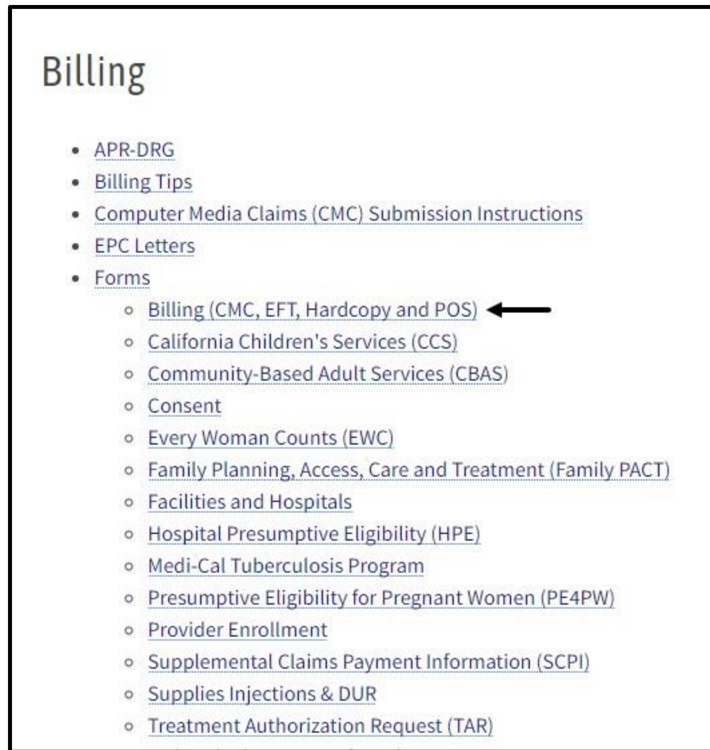


Figure 10: Transaction Enrollment Requirements Page.

3. From the Forms page, expand the Billing (CMC, EFT Payments, Hardcopy & POS) section.

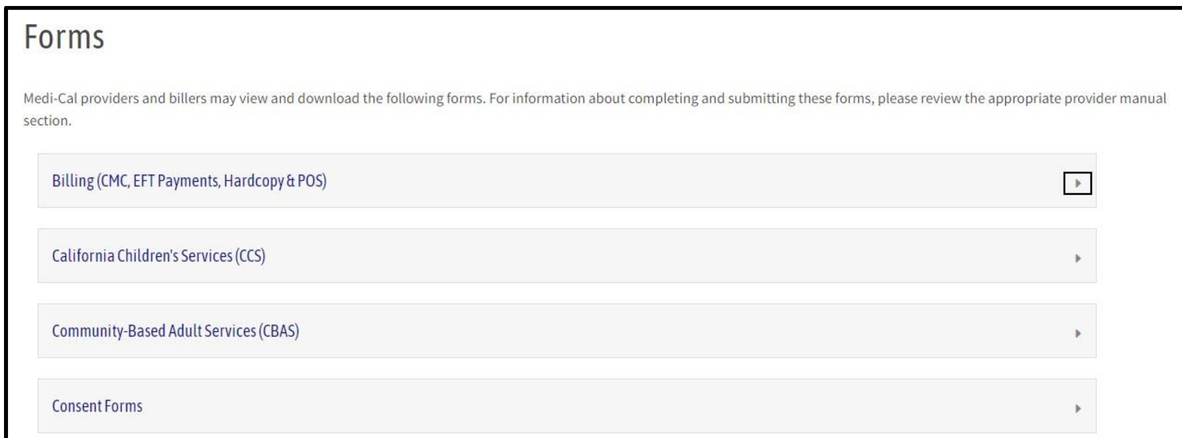


Figure 11: Forms Page with multiple form selections.

4. Navigate to the Point of Service (POS) Network section and select Medi-Cal Point of Service (POS) Network/Internet Agreement.

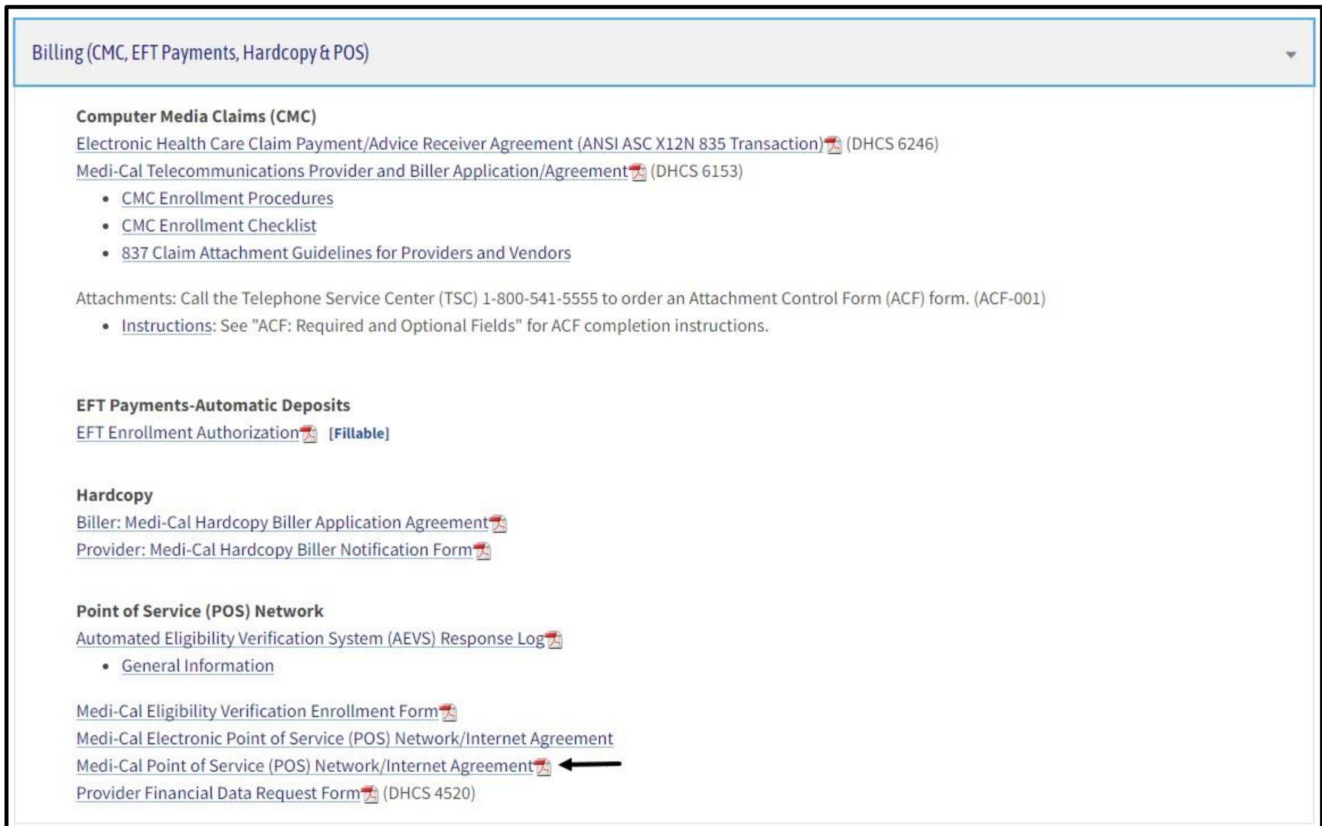


Figure 12: Billing (CMC, EFT Payments, Hardcopy & POS) forms listing page.

To login to the Internet Eligibility Verification, go to the [Medi-Cal Provider website](#).

1. From the Provider drop-down menu, select **Transaction Services.**

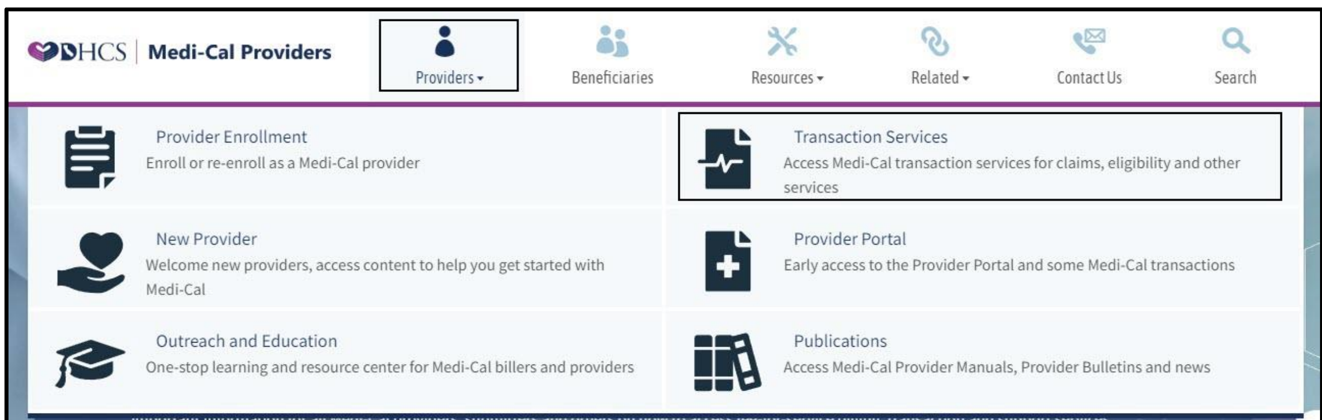


Figure 13: Medi-Cal Provider drop-down menu.

2. Login to Transaction Services with your User ID and Password.

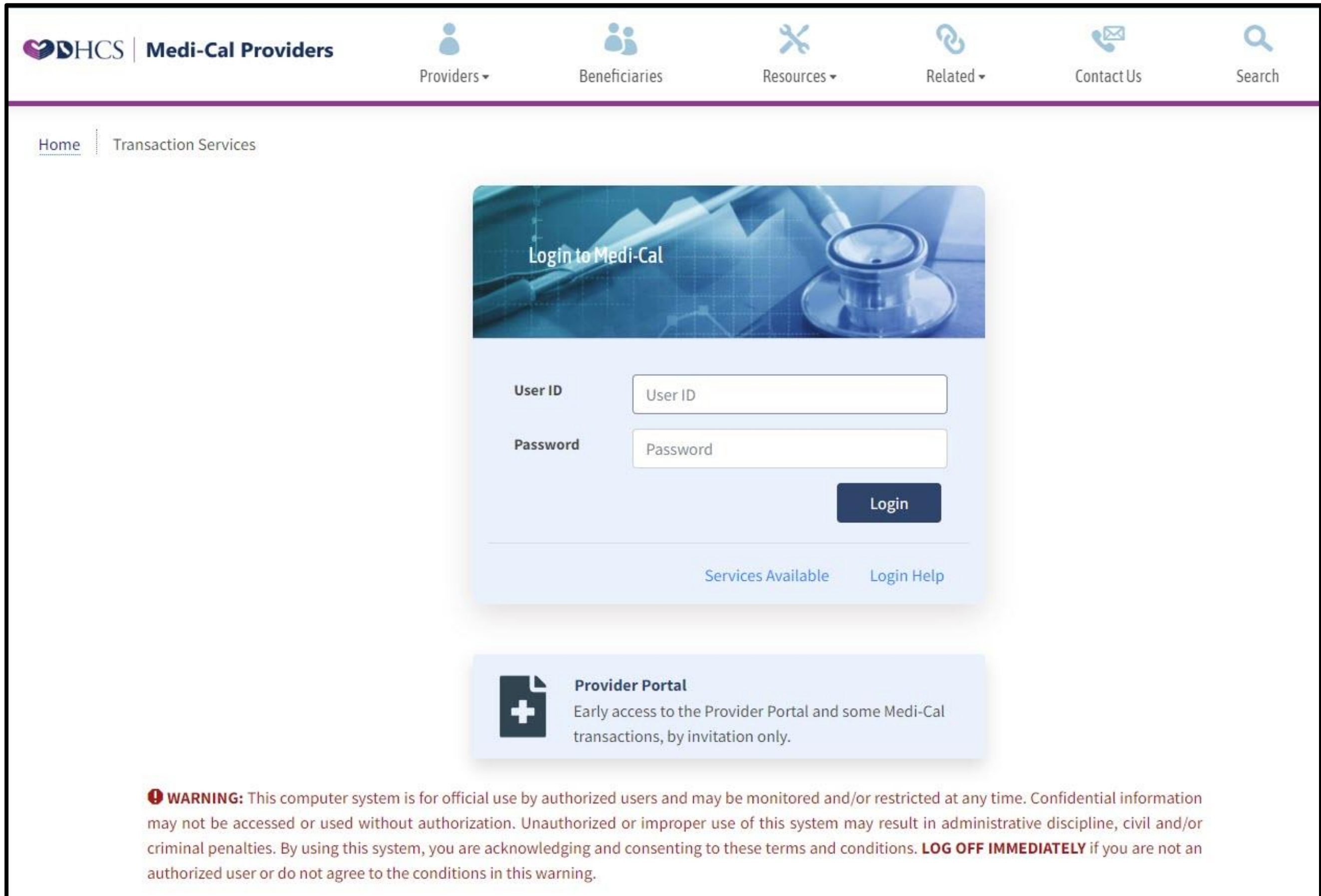


Figure 14: Transaction Services Login Page

3. Select **Single Subscriber.**

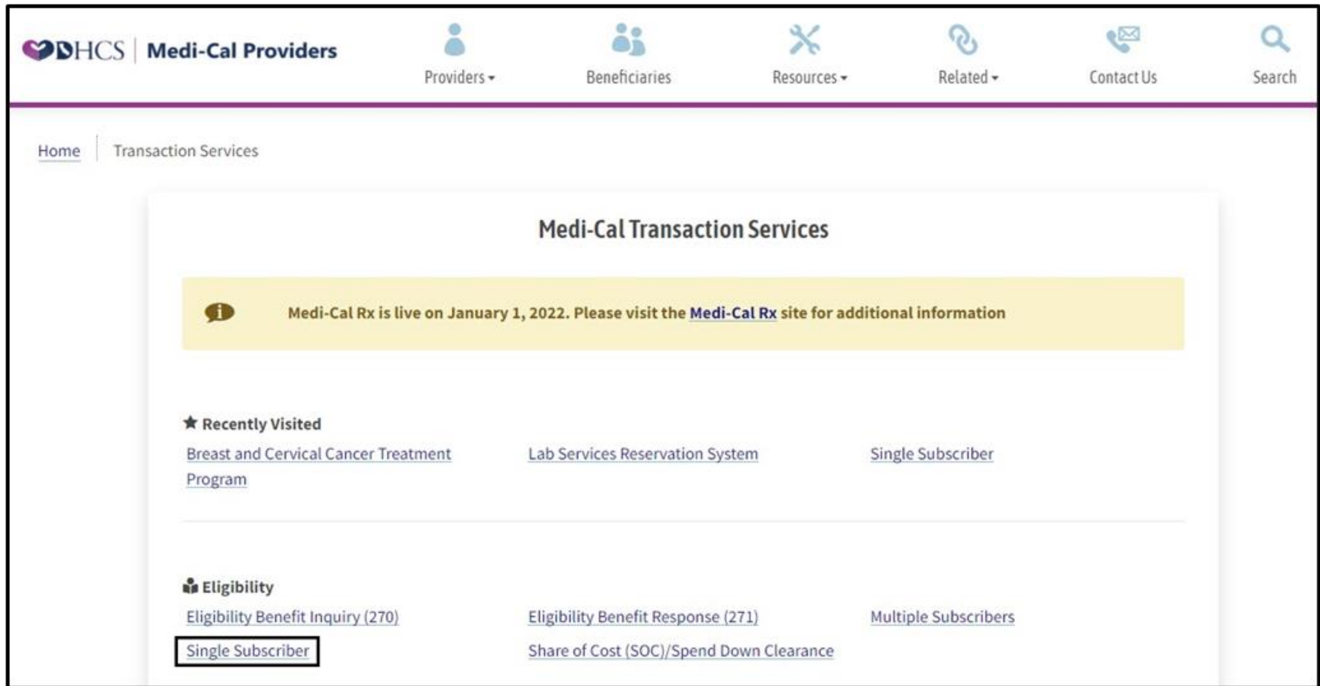


Figure 15: Medi-Cal Transaction Services page – Single Subscriber link

4. Fill out the **Single Subscriber** form and select **Submit.**

Figure 16: Single Subscriber form.

Eligibility Responses

The green banner at the top of the page (with a check mark inside a circle) means eligibility is established, and providers may render services.

Single Subscriber Response

Eligibility transaction performed by provider: on Wednesday, January 12, 2022 at 11:36:44 AM

Eligibility Message: SUBSCRIBER LAST NAME: . EVC #: 901J9V7MM9. CNTY CODE: 02. PRMY AID CODE: 60. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN.

Name:

Subscriber ID:

Service Date: 12/01/2021

Subscriber Birth Date:

Issue Date: 03/08/2013

Primary Aid Code: 60

First Special Aid Code:

Second Special Aid Code:

Third Special Aid Code:

Subscriber County: 02-Alpine

HIC Number:

Trace Number (Eligibility Verification Confirmation (EVC) Number): 901J9V7MM9

Figure 17: Eligibility Message with green banner

The yellow banner at the top (with an exclamation point [!] inside a triangle) directs providers’ attention to special circumstances.

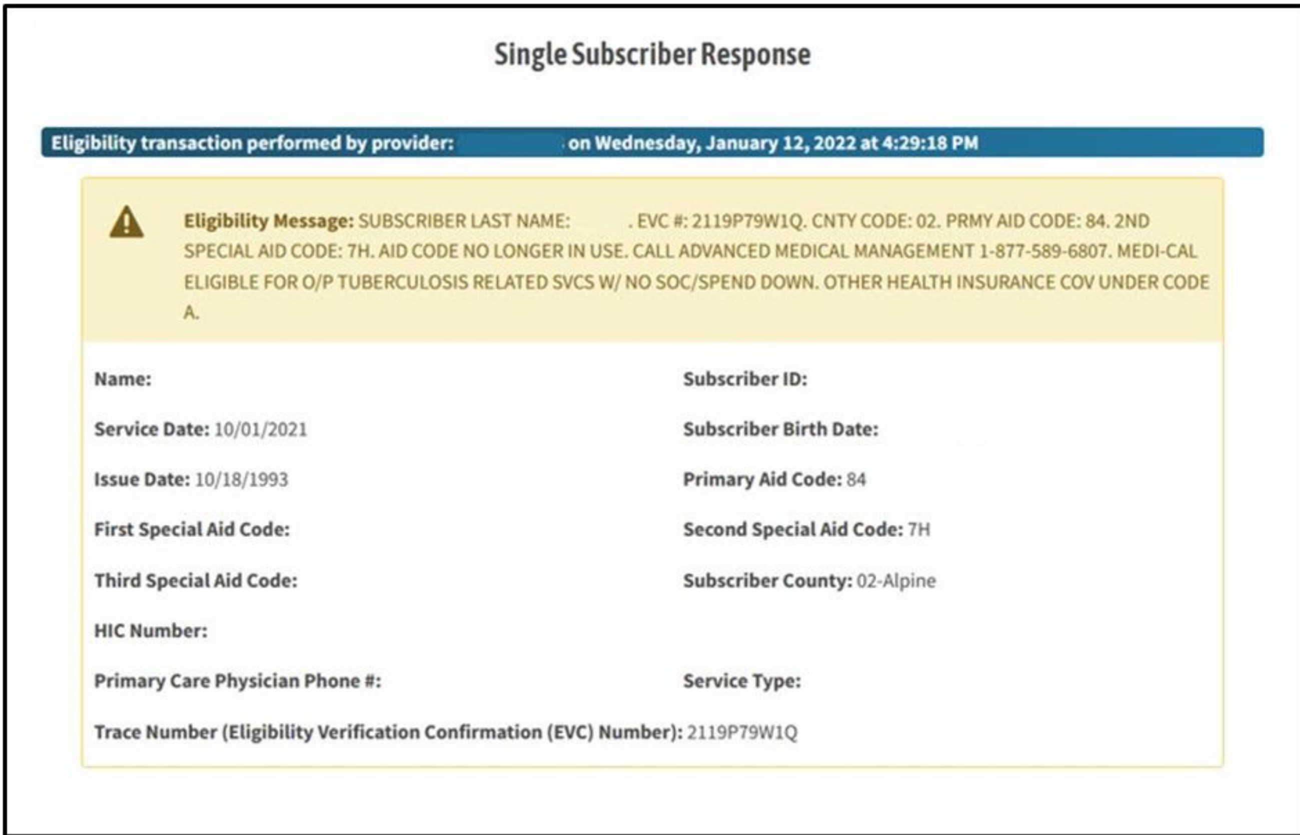


Figure 18: Eligibility Message with yellow banner

The red banner at the top (with a hand inside a hexagon) means no Medi-Cal eligibility.

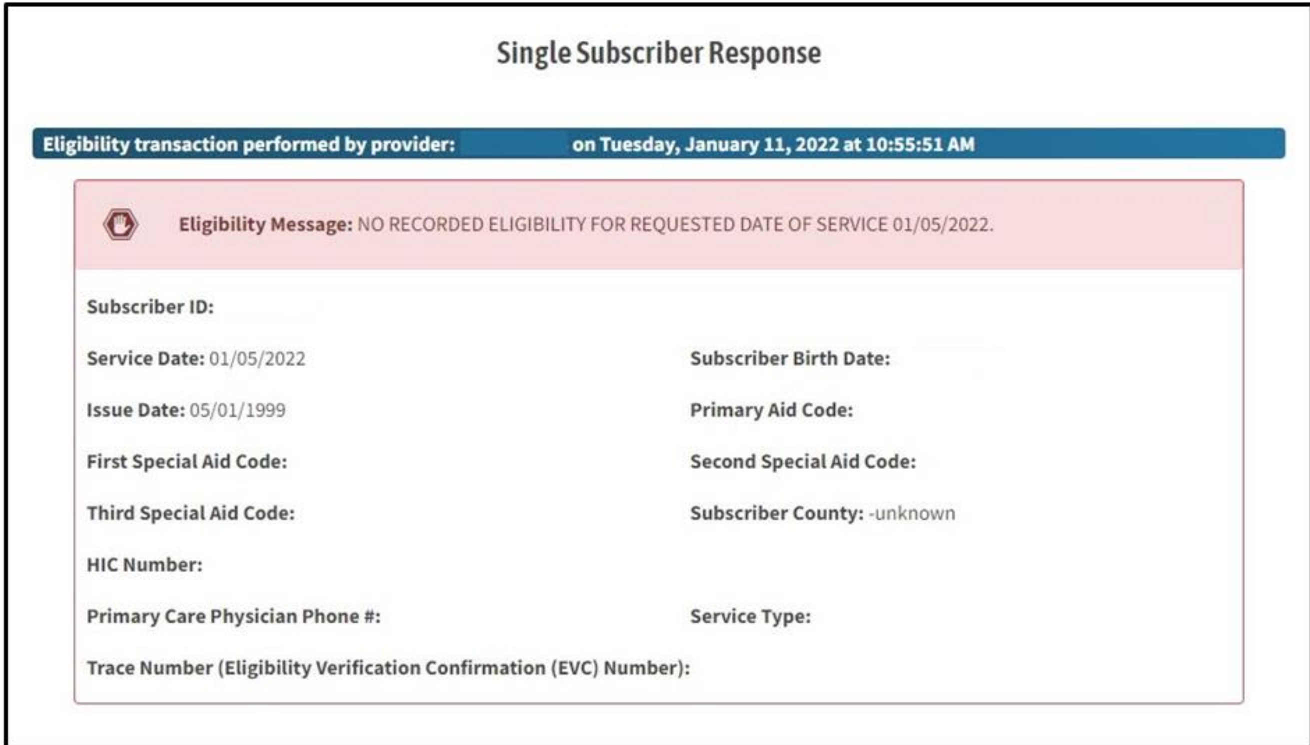


Figure 19: Eligibility Message with red banner

Share of Cost (SOC)/Spend Down Clearance Response

SOC (Spend Down) Amount transaction performed by provider: on 1/13/2022 at 11:20 AM

Eligibility Message: SUBSCRIBER LAST NAME: SOC/SPEND DOWN AMT DEDUCTED: $ 10.00. REMAINING SOC/SPEND DOWN $ 58.00. SOC/SPEND DOWN CLEARANCE APPLIED. MEDI-CAL SUBSCRIBER HAS A $00068 SOC/SPEND DOWN. ELIGIBILITY REPORTED RETROACTIVELY.

Name:

Subscriber ID:

Service Date: 01/05/2022

Subscriber Birth Date:

Issue Date: 03/01/2021

Procedure Code: 99211

Total Claim Charge Amount: 10.00

Case Number:

SOC (Spend Down) Amount Applied: 10.00

Primary Aid Code:

First Special Aid Code:

Second Special Aid Code:

Third Special Aid Code:

Subscriber County:

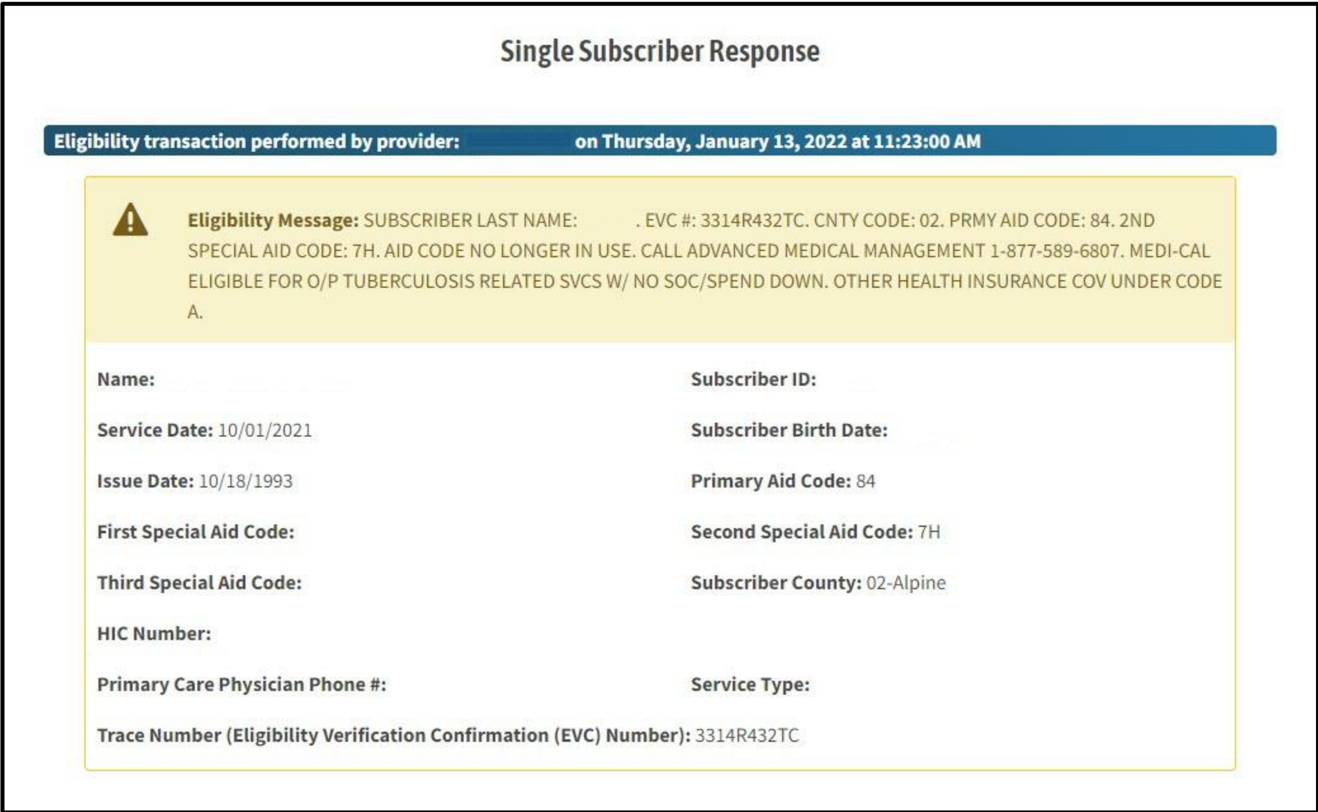
HIC Number:

SOC (Spend Down) Amount Obligation: $68.00

Remaining SOC (Spend Down) Amount: $58.00

Trace Number (Eligibility Verification Confirmation (EVC) Number):

Sample: Medi-Cal Eligible Recipient with a SOC (Share of Cost)



Single Subscriber Response

Eligibility transaction performed by provider: on Thursday, January 13, 2022 at 11:23:00 AM

Eligibility Message: SUBSCRIBER LAST NAME: . EVC #: 3314R432TC. CNTY CODE: 02. PRMY AID CODE: 84. 2ND SPECIAL AID CODE: 7H. AID CODE NO LONGER IN USE. CALL ADVANCED MEDICAL MANAGEMENT 1-877-589-6807. MEDI-CAL ELIGIBLE FOR O/P TUBERCULOSIS RELATED SVCS W/ NO SOC/SPEND DOWN. OTHER HEALTH INSURANCE COV UNDER CODE A.

Name:
Subscriber ID:
Service Date: 10/01/2021
Subscriber Birth Date:
Issue Date: 10/18/1993
Primary Aid Code: 84
First Special Aid Code:
Second Special Aid Code: 7H
Third Special Aid Code:
Subscriber County: 02-Alpine
HIC Number:
Primary Care Physician Phone #:
Service Type:
Trace Number (Eligibility Verification Confirmation (EVC) Number): 3314R432TC

Sample: Medi-Cal Eligible Recipient with OHC (Other Health Coverage)

Knowledge Review 2

To access recipient eligibility, providers must have the following information:

1. ________________________________
2. ________________________________
3. ________________________________

See the Appendix for the Answer Key.

Notes:

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Eligibility Verification by State-Approved Vendor Software

Features

- Providers' existing software may be modified by a vendor
- Providers may purchase a vendor-supplied software package

Automated Eligibility Verification System (AEVS)

The Automated Eligibility Verification System (AEVS) is an interactive voice response system that allows providers to access recipient eligibility, clear Share of Cost (SOC) liability and/or reserve Medi-Services. There is no enrollment requirement to participate in AEVS. Providers must use a valid Provider Identification Number (PIN) to access AEVS. The PIN is issued when providers enroll with Medi-Cal.

AEVS verifies a recipient's eligibility of the current and/or prior 12 months; provides information on SOC, Other Health Coverage (OHC) and Prepaid Health plan (PHP) status; identifies recipients in fee-for-service pending enrollment into a Medi-Cal managed care plan, a Denti-Cal managed care plan or both; identifies any service restrictions, SOC liability and allows podiatrists and certain Allied Health providers to reserve Medi-Services.

Notes:

AEVS accesses the most current recipient information for a specific month of eligibility. AEVS returns a 10-character Eligibility Verification Confirmation (EVC) number, after eligibility is confirmed.

Features

- Free of charge
- Uses a telephone
- Uses alphabetic code list for alphanumeric BICs

Limitations

Limited to 10 inquiries per call

Notes:

Automated Eligibility Verification System (AEVS) Response

Automated Eligibility Verification System (AEVS) Response Log

Transaction Type:

__ Eligibility Verification

__ Share of Cost (SOC)
  __ spend down
  __ reversal

__ Medi-Service
  __ reservation
  __ reversal

Information Entered:

Beneficiary ID #: ________________ Date of Birth: ___________ (mm/yyyy) Date of Service: ____________ (mm/yyyy)

Procedure Code: ____________ (SOC or Medi-Service)

Billed Amount: $____________ (SOC only)

Applied Amount: $____________ (Multiple SOC Cases only) SOC Case #: ____________________
Applied Amount: $____________ (Multiple SOC Cases only) SOC Case #: ____________________
Applied Amount: $____________ (Multiple SOC Cases only) SOC Case #: ____________________

Response from the Network:

Beneficiary Name: ____________________ County Code: _____

Primary Aid Code: _____
1st Special Aid Code: _____
2nd Special Aid Code: _____

Message(s): ____
____
____

Share of Cost (if any): $___________

Case #: _______________ SOC: $_____________
Case #: _______________ SOC: $_____________
Case #: _______________ SOC: $_____________

Medicare Coverage: ___ Part A ___ Part B HIC #: _________________

Other Health Insurance Coverage code: ____

Scope of Coverage (circle those which apply): *V P L O I M COMPREHENSIVE*

Eligibility Verification Confirmation Number: __________________________

Today's Date: ___________________ Transaction performed by: ________________________

(THIS FORM IS FOR YOUR RECORDS ONLY)

1 – AEVS: Transactions
ProPubs

February 2015

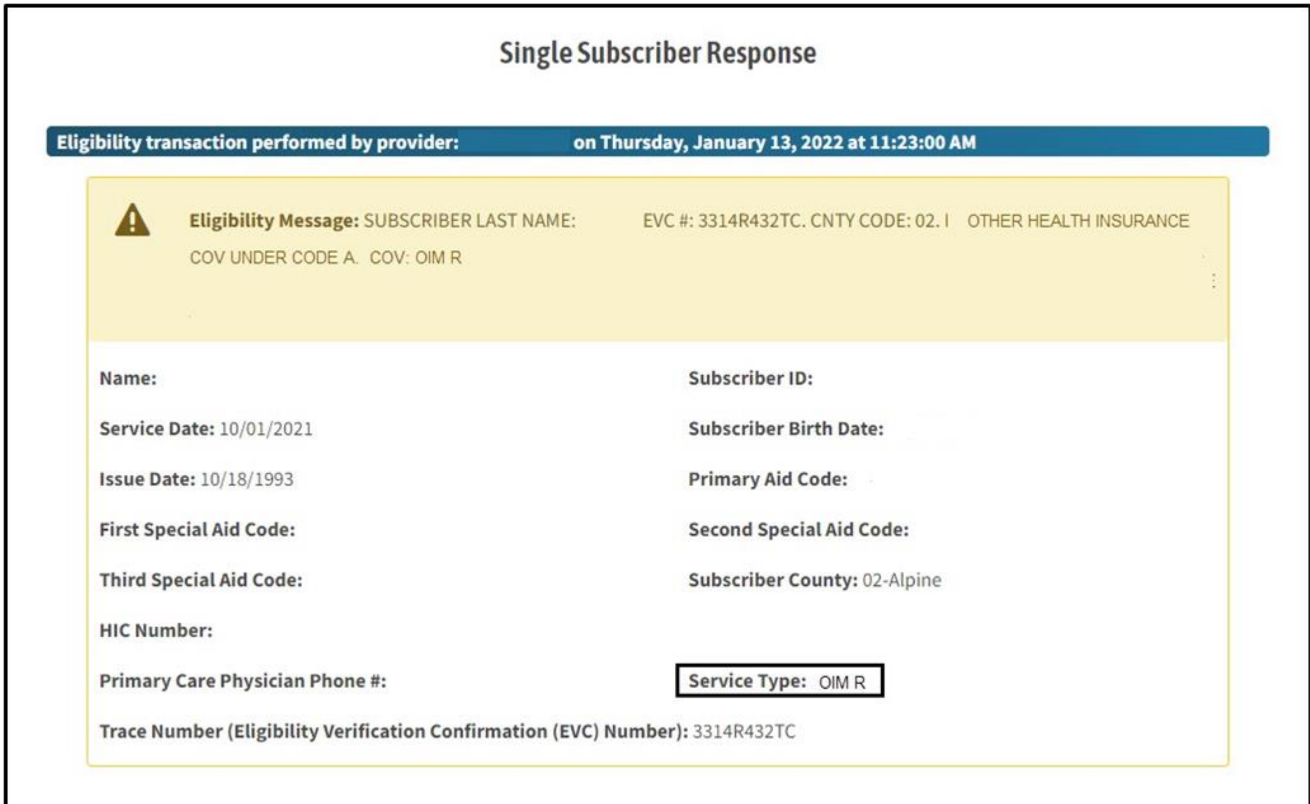
When requesting eligibility verification for a recipient with OHC, the Medi-Cal eligibility verification system returns a message stating a recipient's Scope of Coverage (COV). COV codes designate the specific service categories covered by a recipient's health coverage.

The **Code Explanation** "OIMVLP" explanation means a recipient's insurance covers inpatient, outpatient, medical, vision, long term care and prescription drugs/medical supplies. These are the COV codes and each recipient's plan differs. Each COV code indicates a different set of services. Refer to the COV code chart below or the *Other Health Coverage (OHC) Guidelines for Billing* (other guide) section of the Part 1 provider manual.

Table of Scope of Coverage (COV) Codes

COV Code	Service Category
P	Prescription Drugs/Medical Supplies
L	Long Term Care
I	Hospital Inpatient
O	Hospital Outpatient
M	Medical and Allied Services
V	Vision Care Services
R	Medicare Part D
D	Dental Services

Note: The combination of OHC and COV codes helps providers determine when to bill OHC before billing Medi-Cal.


Single Subscriber Response

Eligibility transaction performed by provider: on Thursday, January 13, 2022 at 11:23:00 AM

Eligibility Message: SUBSCRIBER LAST NAME: EVC #: 3314R432TC. CNTY CODE: 02. I OTHER HEALTH INSURANCE COV UNDER CODE A. COV: OIM R

Name:

Subscriber ID:

Service Date: 10/01/2021

Subscriber Birth Date:

Issue Date: 10/18/1993

Primary Aid Code:

First Special Aid Code:

Second Special Aid Code:

Third Special Aid Code:

Subscriber County: 02-Alpine

HIC Number:

Primary Care Physician Phone #:

Service Type: OIM R

Trace Number (Eligibility Verification Confirmation (EVC) Number): 3314R432TC

Figure 20: Medi-Cal eligible recipient showing the COV codes covered

Resource Information

References

The following reference materials provide Medi-Cal program, eligibility, billing and policy information.

Provider Manual References

Part 1

AEVS – General Instructions (aev gen)
AEVS – Transactions (aev trn)
Aid Codes Master Chart (aid codes)
Eligibility: Recipient Identification (elig rec)
Eligibility: Recipient Identification Cards (elig rec crd)
MCP: Code Directory (mcp code dir)
Other Health Coverage (OHC) Codes Chart (other)
Share of Cost (SOC) (share)

Part 2

California Children's Services (CCS) Program (cal child)
California Children's Services (CCS) Program Eligibility (cal child elig)
Hospital Presumptive Eligibility (HPE) Program Process (hospital presum)
Presumptive Eligibility for Pregnant Women Program Process (presum proc)
Presumptive Eligibility for Pregnant Women (presum)

Specialty Program

EPSDT/CHDP: Gateway Transactions (epsdt chdp gate)

Other References

Internet user guide

Child Health and Disability Prevention (CHDP) Gateway Internet Step-by-Step User Guide

Presumptive Eligibility for Pregnant Women (PE4PW) Application Web Portal User Guide

Hospital Presumptive Eligibility (HPE) Application Web Portal User Guide