

ELIGIBILITY VERIFICATION INSTRUCTIONS FOR USE



Once you have completed the Eligibility Verification User Agreement and Office Ally has linked your account you must complete the Eligibility Settings in Manage Office.

TO COMPLETE THE SET-UPS:

Access the Manage Office tab and locate Eligibility Settings in the Company Settings section.

From the Eligibility Settings link you may designate the default settings for the program to automatically process the eligibility verifications for your office. They are as follows:

A screenshot of a web application dialog box titled "Batch Eligibility Settings". The dialog has a light blue header and a white body. On the left side, there is a vertical stack of papers. The main content area has a yellow background and contains the following controls:

- "Activate Eligibility for all patients" with an "Activate" button.
- "Deactivate Eligibility for all patients" with a "Deactivate" button.
- "Time Zone:" with a dropdown menu currently showing "Pacific Standard Time (PST)".
- "Eligibility Check Frequency:" with a dropdown menu currently showing "Each appointment".
- "Update" and "Cancel" buttons at the bottom.

- **Activate Eligibility for all Patients:** Click Activate to set the flag for all patients in your program. Through the Manage Patient record, you may deselect patients you do not want to verify eligibility on. If you do not wish to activate all patients, you may individually select the patients through their Manage Patient record.
- **Deactivate Eligibility for all Patients:** Click Deactivate to remove the flag for all patients in your program. Through the Manage Patient record, you may select patients you do want to verify eligibility on. If you do not wish to deactivate all patients, you may individually select the patients through their Manage Patient record.
- **Time Zone:** Click the drop down and select the time zone for your office location.
- **Eligibility Check Frequency:** Allows you to select how often you check eligibility for each patient. Currently you may only choose to have eligibility verified for each appointment set. In the future you will have the ability to select to have eligibility verified for each calendar month for a patient versus each appointment.

Once you have completed the settings for your office click "Update" to save them.

INSURANCES

The next step is to link the Insurance record in Manage Office to the Health Plan Eligibility Name.

To Begin, access Manage Office/List Maintenance/Insurances. Edit each insurance record you would like eligibility verified for.

- Locate the “Health Plan Eligibility Name” field
- Click the “Browse” button to access the list of Health Plans available for eligibility verification.
- Search the list and click select to link the Health Plan. Click update to save the information.
- This action will need to be completed for each insurance company you want the system to verify eligibility for.

Desktop | Appointments | Patient Charts | Document Center | References | Patient Portal | Manage Office

Edit Insurance

Insurance Co. ID: 535477

Insurance Name: Aetna

Payer ID: 60054

Address Line 1:

Address Line 2:

City:

State:

Zip:

Contact Name:

Email:

Phone: () -

Fax: () -

Insurance Type: Group Health Plan

Billing Type: EDI

Health Plan Eligibility Name: Aetna

Health Plan Eligibility ID: 246

PROVIDER RECORD

Verify you have correctly entered the provider’s National Provider Identifier (NPI) in the provider record in Manage Office / List Maintenance / Providers

Edit Provider



Provider ID: 143276

First Name: John

Middle Initial:

Last Name: Smith

Social Security No:

State License ID:

NPI: 1234567890

Default Superbill:

The NPI is required and is submitted with the Eligibility Verification request submitted to the health Plan.

MANAGE PATIENTS

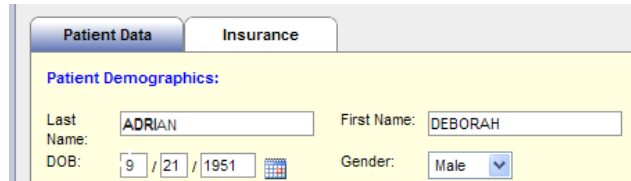
The Insurance Eligibility section will have the setting reflected in the Manage Office, Eligibility section in the Insurance tab.

Note: *If the Health Plan Elig. Name is blank but the Health Plan is linked to the Insurance Co. record in Manage Office you do not have to link it. The first time you schedule an appointment for the patient, the system will update the record in the Manage Patients record.*

The following fields are required elements for Eligibility Verification checking:

Patient Data

- Patient's First Name
- Patient Last Name
- Date of Birth
- Gender

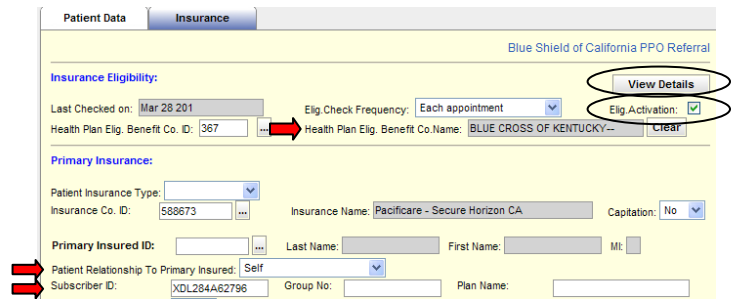


A screenshot of the 'Patient Data' tab in a software interface. The 'Patient Demographics' section is highlighted in yellow. It contains the following fields: Last Name: ADRIAN, First Name: DEBORAH, DOB: 9 / 21 / 1951, and Gender: Male (dropdown menu).

Special Note: *Patients linked to an IPA or Medical Group as the Payer; you must link their actual health plan in the Health Plan Elig. section in order to verify eligibility.*

Insurance

- Health Plan Elig. Benefit Co. Name (defaults from link in Insurance Co. record)
- Patient Relationship to Primary Insured
- Subscriber ID



A screenshot of the 'Insurance' tab in a software interface. The 'Insurance Eligibility' section is highlighted in yellow and includes: Last Checked on: Mar 28 201, Elig. Check Frequency: Each appointment (dropdown), Health Plan Elig. Benefit Co. D: 367, Health Plan Elig. Benefit Co. Name: BLUE CROSS OF KENTUCKY, and an 'Elig. Activation' checkbox which is checked. A 'View Details' button is circled in red. The 'Primary Insurance' section includes: Patient Insurance Type (dropdown), Insurance Co. ID: 588673, Insurance Name: Pacificare - Secure Horizon CA, Capitation: No (dropdown), Primary Insured ID (dropdown), Last Name, First Name, Mt (checkbox), Patient Relationship To Primary Insured: Self (dropdown), and Subscriber ID: XDL284A62796. Red arrows point to the 'Elig. Activation' checkbox and the 'Patient Relationship To Primary Insured' dropdown.

Elig. Activation - You may elect to exclude a patient from the Eligibility Verification process by un-checking the Elig. Activation Box.

View Details – review the last eligibility verification status received on the patient.

Special Note: *If the patient has benefits through a rider for Mental Health, Chiropractic, etc. link the actual Health Plan that the patient is actually enrolled within the Health Plan Benefit Co. Name field. The actual Health Plan is utilized to verify eligibility. The Insurance Co. ID would be linked to the payer you are submitting the actual claim to.*

APPOINTMENTS: SCHEDULING

When you select the patient Health Plan Eligibility Name will populate from the Patient’s record. If this field has not been linked to the patient in Manage Patients you may select the Health Plan from the search list. When you update the appointment the Health Plan Eligibility Name will be updated in the patient’s record.

To exclude a patient from Eligibility Verification checking for this specific appointment uncheck the “Check Eligibility” box.

NPI validation and approval is required prior to submitting eligibility verifications for Medicare patients. If Office Ally identifies your NPI as not registered when you attempt to schedule appointments for your Medicare patients, Office Ally will attempt to automatically register your NPI for you through Ability (Vision Share) . If the validation request comes back approved, you will be able to submit eligibility requests for Medicare patients within 2-3 days. If the validation request comes back denied, you will need to follow steps to verify your provider information is correct with the Medicare NPI Crosswalk/NPPES.

On the appointments tab you will see:

Monday, April 11, 2011											
Time	Patient Name	Status	Provider Name	Primary Insurance	Office	First Name	Last Name	Elig. Status	Elig. Copay	Add	Edit
08:00	[REDACTED]	Active	Florida Medicare	MEDICARE NEBRASKA	North County Office	[REDACTED]	[REDACTED]	Not Eligible		[Pencil]	[X]
	[REDACTED]	Active	Florida Medicare	MEDICARE DISTRICT OF COLUMBIA	North County Office	[REDACTED]	[REDACTED]	Eligible	\$	[Pencil]	[X]
	[REDACTED]	Active	Florida Medicare	Medicare Washington	North County Office	[REDACTED]	[REDACTED]	Do Not Check		[Pencil]	[X]
	[REDACTED]	Active	Florida Medicare		North County Office	[REDACTED]	[REDACTED]	pending		[Pencil]	[X]
	[REDACTED]	Active	Florida Medicare	MEDICARE ALASKA	North County Office	[REDACTED]	[REDACTED]	Invalid		[Pencil]	[X]
:15	[REDACTED]	Active	Florida Medicare	MEDICARE ALASKA	North County Office	[REDACTED]	[REDACTED]	Invalid		[Pencil]	[X]

- Provider/Staff
- Provider/Staff/Resources
- Weekly View

From 4

Mon 4/4/2011 Tue 4/5/2011

08:00 am BARRYSMITH, COO Edit Appointment

08:15 08:15 08:15 DEVOR, FIELDS PAL Add Appointment

08:30 am 08:30 am DEVORE, MANNII Delete Appointment

08:45 08:45 08:45 HIBBAR, PADUA FIEL Check In

09:00 am ANDERSON, ALEX Open Chart

09:15 am View Elig. Status

Elig. Status will display the status of the verification

- By clicking the status you will be able to see further details related to the verification.
 - **Do Not Check** – User elected not to check eligibility for the patient
 - **Eligible** – Response returned indicating the patient is eligible
 - **Invalid** – Response returned indicating either the patient information submitted is invalid (transaction fee will apply) or the request failed to reach the insurance company (transaction fee will not apply), a total of three attempts are made at no additional fee for failed to reach the insurance company. **View the returned status for further details.**
 - **Not Eligible** – Response returned indicating the patient is not eligible
 - **Pending** – Response pending from the insurance company

Elig. Copay – Amount of the copay indicated for the patient by the insurance company

Check Now – For newly added appointments, to recheck invalid responses or for any appointment you want to check eligibility NOW, simply click the “Check Now” link located within the status page.



EXAMPLES OF ELIG. STATUS AND ELIG. COPAY RESPONSES

To view responses click on the status or \$ sign within the appointment record.

Elig. Status (Eligible)

Insurance Status

Eligibility Benefits

Medicare Part A

Active Coverage - Medicare Part A

Coverage : Individual
 Insurance Type : Medicare Part A
 Eligibility : 08/01/2008

Hospital

Co-Payment - Medicare Part A

Insurance Type : Medicare Part A
 Time Period : Remaining
 Amount : \$283
 Days : 30

Elig. Status (Not Eligible)

Insurance Status

[Check Now](#)

Payer Information

Payor Id : CMS
 CMS

Provider Information

National Provider Identifier : 1235285347

Insured or Subscriber Information

Name : ██████████
 Member Id : ██████████
 Address : ██████████
 Date Of Birth : ██████████
 Gender : Male
 Eligibility : 04/11/2011
 442 : 05/13/2010

Eligibility Benefits

Inactive

Elig. Copay(\$)

Co-Payment

Co-Payment -

Time Period : Visit
 Amount : \$40
 In Plan Network : Yes
 Note : SPECIALIST
 Note : PHO COPAY

Physician Visit - Office

Co-Payment -

Time Period : Visit
 Amount : \$40
 In Plan Network : Yes
 Note : PHO COPAY

SPECIAL NOTES

IPA/Medical Groups – If the patient is linked to an IPA or Medical Group as the Payer in the Insurance Co. field, you must link their actual health plan in the Health Plan Elig. Co. ID field in the Insurance Eligibility section of the patient record in Manage Patients / Insurance tab.

Insurance to Health Plan links - Office Ally will map the current available health plans to the insurance records in Manage Office. In the event Office Ally miss-mapped an insurance to a health plan simply access the Eligibility Settings section in Manage Office. Click on the “Deactivate” button to remove all patient settings.

Invalid Verification Requests – There are various types of invalid verification requests. If the invalid request is due to inaccurate or missing patient/insurance information you will receive a transaction fee for the request. However, if the invalid request is due to a failure of the request to reach the Health Plan to verify the submission you will not receive a transaction fee. Up to three submissions will be made to complete the transaction. If all 3 attempts fail you will not receive the transaction fee. If one of three attempts is successful, you will receive one transaction fee.

Rider Benefits - If the patient has benefits through a rider for Mental Health, Chiropractic, etc. link the actual Health Plan that the patient is actually enrolled within the Health Plan Benefit Co. Name field. The actual Health Plan is utilized to verify eligibility. The Insurance Co. ID would be linked to the payer you are submitting the actual claim to.

Time Zone – It is important you select the appropriate time zone for your office location. This is to ensure requests are submitted and responses returned within the appropriate time lines for your office hours.