How to verify Oregon Health Plan (OHP) eligibility and enrollment

Benefit plan indicates member's level of OHP coverage

The "Benefit Plan" section of the Eligibility Verification Screen shows the level of coverage available.

- **BMH (OHP Plus).** This plan offers comprehensive coverage; see the OHP benefits chart or Oregon Administrative Rule (OAR) 410-120-1210(4)(a).
- **BMD, BMM (OHP with Limited Drug).** This plan offers the same benefits as OHP Plus, except drug coverage is limited to drugs that OHP Plus covers, but Medicare Part D doesn't. See OAR 410-120-1210(4)(b). The BMM plan covers Medicare coinsurance and deductibles as described in OAR 410-120-1210(4)(c)(C).
- **CWM (Citizenship Waived Medical).** This plan covers emergency medical, emergency dental and emergency transport services; treatment for end-stage renal disease (kidney failure); cancer treatment; behavioral health crisis services; reproductive health services. See OAR 410-134-0003(1-2).
- **CWX (CWM Plus).** This plan offers the same benefits as OHP Plus, except for hospice care, sterilization, abortion and Death with Dignity services. See OAR 410-134-0003(3).
- **DEN, DNT (OHP Dental).** This plan offers dental benefits only. See OAR 410-120-1210(4)(e-f).
- **MED (Qualified Medicare Beneficiary).** This plan only covers Medicare coinsurance and deductibles as described in OAR 410-120-1210(4)(c).

Identifying fee-for-service ("open-card") members and CCO members

The "Managed Care" section of the Eligibility Verification Screen shows the member's CCO. The following chart explains what and whom to bill based on member enrollment.

Plan type displayed	Who is responsible for payment?		
	Behavioral health	Dental	Physical health
CCOA	CCO	CCO	CCO
CCOB	CCO	OHA	CCO
CCOE	CCO	OHA	OHA
CCOF	—	CCO	—
CCOG	CCO	CCO	OHA
None of the above	OHA	OHA	OHA

How to view service types covered for OHP benefit plans

To find out what a specific benefit plan covers, click on the plan in the "Benefit Plan" section of the Eligibility Verification Screen. Covered service types will display in the "Service Type Coverage" section. Non-covered service types will **not** display.

- Some covered services may have limitations; refer to OAR 410-120-1210 for limitations by benefit plan limitations. Also see the program-specific guidelines for the service type (*e.g.,* Dental Services guidelines for dental limitations).
- To view service-specific coverage information, use the Benefits and HSC List inquiry for FFS ("open card") members. For CCO members, contact the CCO.

When enrollment shows private health insurance or Medicare

Please bill all other payers first. To learn more, please review our Third Party Liability fact sheet.

Verifying atypical eligibility — For people not yet in our eligibility system

Members approved for OHP eligibility through HealthCare.gov or the Hospital Presumptive Eligibility (HPE) process will **not** be in our system right away. For these people, accept the following proofs of eligibility, and wait until you have verified that the member is in our system before billing OHA.

- **For HealthCare.gov approvals**: HealthCare.gov eligibility determination letter. This letter guarantees eligibility from the *Application Date* listed on the letter. There is no end date on the letter.
- **For HPE approvals:** HPE Approval Letter, issued by an approved HPE determination site. Eligibility is effective from the *Date of Notice* at the top of the letter through the last day of the month following the date of notice. After that, the member must submit a full OHP application to see if they still qualify.

Once the member's eligibility is in our system, we will issue their Oregon Health ID card. Please ask members for this card and use the Client ID on the card for future eligibility and enrollment checks.