
Eligibility: Recipient Identification

Page updated: August 2020

Recipient eligibility information is divided into four areas. Refer to the appropriate section in this manual for detailed information about the following topics:

- Eligibility: Recipient Identification
- Eligibility: Recipient Identification Cards
- Eligibility: Service Restrictions
- Eligibility: Special Groups

Recipient Identification: Provider Obligations

When a provider verifies that an individual is eligible to receive Medi-Cal benefits, (by this act) the provider is accepting the individual as a Medi-Cal recipient. The provider is then bound by the rules and regulations governing the Medi-Cal program in regard to that recipient. The provider is then bound by the rules and regulations governing the Medi-Cal program in regard to that recipient. For more information, refer to the *Welfare and Institutions Code (W&I Code)*, Sections 14018.2 and 14019.4. 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 a provider verifying that an individual is eligible to receive Medi-Cal benefits, the provider must make a good faith effort to verify the identity of the recipient by matching the recipient's name and signature on their Medi-Cal card with a valid California driver's license, ID card issued by the Department of Motor Vehicles, another type of picture identification card or other credible document of identification.

The provider must document the "good faith effort" by making a copy of the Benefits Identification Card (BIC) and a copy of the identification card/document (referenced above) that was used to compare signatures. The provider's documented "good faith effort" to verify the recipient's ID will be a consideration in assessing the validity of the medical claim.

If the recipient does not have one of the identification documents specified above, the provider must document that the recipient failed to provide the identification document by recording this in the medical file. If DHCS later determines that the patient who received the medical services is not the Medi-Cal recipient, the provider may be required to refund reimbursements associated with these services to Medi-Cal.

Exceptions: The identification requirement is waived for persons 17 years of age and younger, persons in long term care and individuals receiving emergency care.

For patients receiving emergency services, this exception applies only for the duration of the medical emergency. After the emergency services terminate, and prior to providing any non-emergency services or releasing the recipient from care (whether emergency room, hospital, clinic or other medical services provider), the provider must confirm the recipient's identity as specified by the "good faith effort" described above.

When verifying a recipient's eligibility, Automated Eligibility Verification System (AEVS) may return the message, "For claims payment, current BIC ID number and date of issue required." This message indicates that the individual was issued a new Benefits Identification Card (BIC) because their previous BIC was reported as lost or stolen or may have been misused. If the most recent BIC ID number and issue date are not on the claim, the claim will be denied. (Refer to the *Eligibility: Recipient Identification Cards* section for more information about the BIC.)

Eligibility Verification

Providers are advised to always verify eligibility for Medi-Cal recipients on the date of service. Certain programs require eligibility to be verified on the date of service, such as the Medi-Cal County Inmate Program (MCIP).

Month-to-Month Eligibility

«Providers must verify eligibility every month for each recipient who presents a plastic BIC, Medi-Cal Eligibility Confirmation Letter 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.

Note: Eligibility may be verified only for the current month and up to the previous 12 months, never for future months.

Point of Service (POS) Network

The Point of Service (POS) network is set up to verify eligibility, perform Share of Cost and Medi-Services Requests and perform Family PACT (Planning, Access, Care and Treatment) Program transactions. The POS network may be accessed through the Automated Eligibility Verification System (AEVS), the internet or state-approved vendor software.

Automated Eligibility Verification System (AEVS)

An Eligibility Verification Confirmation (EVC) number verifies that an inquiry was received and eligibility information was transmitted. (Refer to the *AEVS: General Instructions* section in this manual for information about using telephone AEVS.)

Internet

The Medi-Cal Web site on the Internet at www.medi-cal.ca.gov allows providers to verify recipient eligibility, clear Share of Cost liability and reserve Medi-Services. An EVC number on the Internet eligibility response verifies that an inquiry was received and eligibility information was transmitted. This response should be printed and kept in the recipient's file.

State-Approved Vendor Software

Providers' existing software may be modified by a vendor or providers may purchase a vendor-supplied software package capable of performing these transactions. An EVC number verifies that an inquiry was received and eligibility information was transmitted.

Note: Receipt of an EVC number does not guarantee claim payment. Providers should carefully review all information returned with the eligibility response to ensure that their services are covered under a recipient's eligibility. An EVC number will not be issued if an individual is ineligible.

Retroactive Eligibility

Some Medi-Cal recipients become eligible for Medi-Cal after the month in which services were rendered. When submitting claims for Medi-Cal recipients who have retroactive eligibility, complete the claim form in the same manner as for other late billings. (Refer to "Timelines for Claims" in the *Claim Submission and Timeliness Overview* section in this manual and the submission and timeliness instructions section of the appropriate Part 2 manual for information about late billing.)

In this situation, the provider of services has 60 days from the date of receipt of retroactive eligibility information to bill the Medi-Cal program. Proof of eligibility must be received within one year from the month the service was rendered. To verify retroactive eligibility, providers may access the POS network or visit the Medi-Cal Web site at www.medi-cal.ca.gov. The message "Eligibility Reported Retroactively" will advise providers that although the recipient is currently showing Medi-Cal eligibility for a month in which a service was provided, the eligibility for that month had not been established when the service was first rendered.

Note: Medi-Cal field offices will accept the “Eligibility Reported Retroactively” message as proof that eligibility was not established for the recipient on the original date of service.

For more information regarding retroactive eligibility and payment, refer to “Retroactive Eligibility: Provider Obligations” in the *Provider Regulations* section in this manual.

Medi-Services

Medi-Services are used by Allied Health, Medical Services and Outpatient providers. The following providers should reserve a Medi-Service before billing for certain services: acupuncturists, audiologists, chiropractors, occupational therapists, podiatrists, psychologists and speech pathologists.

Most recipients eligible for Medi-Cal are allowed two Medi-Services per calendar month. Medi-Services can be reserved using a telephone AEVS, the Medi-Cal website on the internet at www.medi-cal.ca.gov or certain state-approved vendor software packages. The procedure code on the reservation must match the procedure code on the claim to be reimbursed. If the code billed is different than the code reserved, reverse the reservation and resubmit it with the correct code.

If a Medi-Service is not reserved before a claim reaches the claims processing system, and if no reservations are left for a recipient for the month of service, the claim will be denied.

If the date of service on the claim does not match the Medi-Service reservation, the Medi-Service reservation will automatically be reversed and re-reserved with the date of service on the claim.

Note: Medi-Service reservations will be automatically reversed and re-reserved only if the date of service on the claim and the Medi-Service reservation date fall within the same month and year.

Providers should not reserve a Medi-Service unless certain that 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.

County Code Definition

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 (referred to as the county of responsibility or county of jurisdiction for foster youth). The county of responsibility may be different from the county of residence. The county of residence indicates the county the individual physically resides in.

«Legend»

«Symbols used in the document above are explained in the following table.»

Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.