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

Benefit packages indicate member's level of OHP coverage

The "Benefit Plan" section of the Eligibility Verification Screen shows the member's benefit packages.

BMH (OHP Plus).

OHP Plus offers comprehensive coverage; see Oregon Administrative Rule (OAR) 410-120-1210(4)(a).

BMD, BMM (OHP with Limited Drug).

OHP with Limited Drug 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 benefit package also covers Medicare coinsurance and deductibles as described in OAR 410-120-1210(4)(c)(C).
- For members with BMD or BMM benefits, bill Medicare primary for any services that Medicare covers.

BRG (OHP Bridge)

OHP Bridge offers the same benefits as OHP Plus for adults, except for long-term care services and supports and Health-Related Social Needs benefits. See OAR 410-11-0030.

DEN, DNT (OHP Dental).

OHP Dental offers dental benefits only. See OAR 410-120-1210(4)(e-f).

MED (Qualified Medicare Beneficiary).

This benefit package only covers Medicare coinsurance and deductibles as described in OAR 410-120-1210(4)(c).

Identifying fee-for-service ("open card") members and coordinated care organization (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	Behavioral health	Dental	Physical health
CCOA	Bill CCO	Bill CCO	Bill CCO
CCOB	Bill CCO	Bill OHA	Bill CCO
CCOE	Bill CCO	Bill OHA	Bill OHA
CCOF	Bill OHA	Bill CCO	Bill OHA
CCOG	Bill CCO	Bill CCO	Bill OHA
None of the above	Bill OHA	Bill OHA	Bill 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 fee-for-service ("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.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact OHP Provider Services at dmap.providerservices@oha.oregon.gov or 800-336-6016. We accept all relay calls.