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

Benefit plan indicates client'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) in the General Rules.
- **BMD, BMM (OHP with Limited Drug).** This plan offers the same benefits as OHP Plus, except that OHP Plus drug coverage is limited only to drugs that are not already covered by Medicare Part D. See OAR 410-120-1210(4)(b). People with BMM also have Medicare coinsurance and deductibles paid as described in OAR 410-120-1210(4)(c)(C).
- **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 410-120-1210(4)(e).

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

The "Managed Care" section of the Eligibility Verification Screen shows any CCO/plans the client is enrolled in. The following chart explains what and whom to bill based on client's enrollment.

Plan type displayed	Who is responsible for payment?		
	Behavioral health	Dental	Physical health
CCOA	CCO	CCO	CCO
CCOB	CCO	OHA or DCO	CCO
CCOE	CCO	OHA or DCO	OHA
CCOG	CCO	CCO	OHA
None listed	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 OHP benefit plan in the "Benefit Plan" section of the Eligibility Verification Screen. Covered service types and copayment information will display in the "Service Type Coverage and Copay" section. Non-covered service types will **not** display.

- Some covered services may state there are limitations; refer to OAR 410-120-1210 in the General Rules for benefit plan limitations, and 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 clients, or contact the CCO/plan for CCO/plan members.

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

Clients 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 client 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 client must submit a full OHP application to see if they still qualify.

Once client eligibility has been entered into our system, we will issue the clients their Oregon Health ID cards. Please ask clients for this card and use the Client ID on the card for future eligibility and enrollment checks.