## Section 1

### Financial Status Classification

**Section Objectives**

- Enter new insurance information
- Identify various insurance plans and Financial Status Classifications
- Prioritize FSC in the appropriate manner
- Edit existing insurance
A) What are Financial Status Classifications (FSC)?

FSCs are the means by which a patient’s financial status/insurance is registered in IDX. Every insurance card will fall into a FSC category.

**FSC OPTIONS**

<table>
<thead>
<tr>
<th>Key</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Add new insurance <em>(will automatically default based system priority settings)</em></td>
</tr>
<tr>
<td>E</td>
<td>Edit existing insurance</td>
</tr>
<tr>
<td>I</td>
<td>Insert a new insurance</td>
</tr>
<tr>
<td>C</td>
<td>Copy <em>(not used at our organization-RowanSOM)</em></td>
</tr>
<tr>
<td>J</td>
<td>Documents <em>(not used at our organization-RowanSOM)</em></td>
</tr>
<tr>
<td>S</td>
<td>Shows deleted FSCs</td>
</tr>
<tr>
<td>T</td>
<td>Allows users to view changes made to insurance plan</td>
</tr>
<tr>
<td>H</td>
<td>Change a FSC priority</td>
</tr>
<tr>
<td>V</td>
<td>View FSC detail <em>(cannot edit)</em></td>
</tr>
<tr>
<td>B</td>
<td>Determinator – <em>future enhancement</em></td>
</tr>
</tbody>
</table>
All FSCs must be entered correctly in order to receive prompt and accurate payment. Once the pages of registration are filed, the “Manage Insurance Information” screen will appear. The screen will enable you to add or make changes to a person’s insurance information.

**Features:**
- Use up & down arrow keys to move to another line
- Click the **OK** button to save & exit

**In order to get to the Insurance Detail:**

1. Select Patient Services from the Vertical Toolbar (VT)
2. Make patient selection at Name prompt:
3. Select the <Insurance> hyper link
4. Select the appropriate Action Code from the list
B) Changing Insurance Prioritization

In order to get to the Insurance Prioritization:

1. Select Patient Services from the Vertical Toolbar (VT)
2. Make patient selection at the name prompt
3. Select the <Insurance> hyper link
4. Highlight FSC to be moved and choose Option H – Change Order
5. Select D to move FSC down in priority order or U to move FSC up in priority order
C) Required Elements for Payment

Commercial, BC/BS and Managed Care

- It’s imperative users confirm and differentiate placement of guarantor information vs., subscriber information vs. patient information. Inadvertently populating this information in error will negatively impact the revenue cycle
- Insurance Company claim address
- Certificate and Group numbers
- Subscriber Name (if different) enter name as it appears electronic on the validation tool or insurance card (when unable to validate coverage)
- Relationship to Subscriber: enter the value provided during validation or insurance card (when unable to validate coverage)
- Subscriber’s date of birth
- Subscriber’s sex
- Subscriber’s address

Medicare

- Suffix or prefix and beneficiary number
- Medicare Eligibility Date. (If unknown, enter the Medicare part A effective date.)
- MSP questionnaire
- Subscriber Name (if different) enter name as it appears electronic on the validation tool or insurance card (when unable to validate coverage)
- Subscriber’s address

Medicaid (Any or all of these fields may be required)

- Certificate Number (10-digits)
- Person Patient Number (2-digits)
- Case Worker’s Name (Last name, First Name)
- Case Worker’s Phone Number
- Case Number
- Relationship to subscriber (self)
- Subscriber Name (if different) enter name as it appears electronic on the validation tool or insurance card (when unable to validate coverage)
- Subscriber’s address
D) Coordination of Benefits (COB)

Coordination of benefits (COB) is required when there are two or more insurance carriers with potential liability for a claim.

- Except in the case of Medicare, the patient’s insurance is always primary and spousal insurance is secondary.

- Insurance for a Medicare patient with an insured working spouse should be registered with the working spousal insurance as primary and Medicare as secondary (Refer to the Medicare Section).

- The Birthday Rule applies to dependent children covered under both parents’ plans. The parent whose birthday is first in the year by month and day is designated as the primary plan. The other parent’s coverage is secondary. If both parents are born on the same month and day, the parent with whose insurance was in effect first is primary. The year a parent was born is never applicable with the Birthday Rule.

- Workers’ Compensation (WC) coverage is primary for all services rendered as result of a work related injury in conjunction with benefits assigned by carrier.

- Generally Automobile insurance also referred to as No-Fault (NF) is primary for services rendered as a result of injuries sustained in an automobile accident provided the incident did not occur while the individual was working (Please confirm the patient’s selection).

- The medical insurance should always be captured even in cases of WC or auto related services because this is a shared system. It is possible for a patient to be treated for a WC or auto injury and also be treated for a medical condition not related to their accident.
E) Physician/Hospital Component

- Capture ALL insurance coverage

- Supplemental insurance covers the 20% left after Medicare has paid. It should always follow Medicare Part B in the billing order.

**Example 3.1**

| Medicare Part B | 65 Special |

- **Medicare A** → Pays Hospital Admission
- **Medicare B** → Pays physician visits, outpatient hospital services and ancillary testing such as labs and x-rays
- **Medicare C** → Medicare Advantage (*Medicare Replacement Plans*)
- **Medicare D** → Prescription Drug Benefit
- **Blue Cross** → Pays all hospital charges (in-stays, outpatient visits and ancillary services.)
- **Blue Shield** → Pays Physician Visits
F) Expired Insurance

Three steps to expiring insurance:

1. Enter an expiration date in the old insurance.
   - If unknown use the last day of the previous month.

2. Add the new insurance with an effective date.
   - Do not use a fictitious date in this field. If actual effective date is unknown, leave this field blank.

3. Swap the old insurance to last in the billing order.

In the case where the insurance company is the same but the identification numbers, group numbers or type of plan has changed; the system will not allow the new insurance to be added because the plan codes are the same. In order to keep the old information for outstanding billing issues; enter the previous policy information (i.e. Identification number/Certificate number, group number, group name, subscriber’s information) as described below:

- FSC – 54 NJ B/S 2ND - for all Horizon BC/BS FSCs
- FCS – 41 Commercial Insurance – for all plans other than Horizon BC/BS
- Edit existing FSC(s) to reflect the new plan information.
G) Informational FSCs

Informational FSCs have no financial value at all. They are entered in accounts as flags to bring our attention to certain accounts. Additionally, the patient banner will reflect this information.

<table>
<thead>
<tr>
<th>#</th>
<th>FSC</th>
<th>CERTIFICATION/GRP-PERS#/PLAN/#SUBSCRIBER</th>
<th>EFFECTIVE DATE</th>
<th>EXPIRATION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>BAD</td>
<td>/</td>
<td>03/16/2013-09/16/2012</td>
<td>/</td>
</tr>
<tr>
<td>50</td>
<td>AHP</td>
<td>W123456789/55555/TEST-GRABLE,WILLIAM</td>
<td>01/01/2003-</td>
<td>01/01/2003-</td>
</tr>
<tr>
<td>46</td>
<td>USH</td>
<td>AABBCDD/44444/TEST-GRABLE,JANE</td>
<td>01/01/2003-</td>
<td>01/01/2003-</td>
</tr>
<tr>
<td>551</td>
<td>ACNI</td>
<td>1111111111/TEST-GRABLE,WILLIAM</td>
<td>01/01/2002-12/31/2002</td>
<td>/</td>
</tr>
<tr>
<td>101</td>
<td>NIMA</td>
<td>1111111111/TEST-GRABLE,WILLIAM</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>145</td>
<td>AMHC</td>
<td>1111111111/555555/TEST-GRABLE,WILLIAM</td>
<td>01/01/2003-</td>
<td>01/01/2003-</td>
</tr>
</tbody>
</table>

FSC 7 Bad Address

- A FSC 7 is added to an account when a patient’s address is known to be incorrect.
- The FSC 7 will suppress statements so that they are not sent to an incorrect address.
- The FSC 7 should be added after active insurance with an effective date and expiration date.

**EFFECTIVE DATE:**
**EXPIRATION DATE:** Entered when updated address data is received

- Enter the bad address information in general comments.
Updating An Account With A Bad Address FSC

- ALL accounts must be checked for a Bad Address FSC

1. Update the address on page 1
2. Update General Comments with the change (old address)
3. Expire Bad Address FSC with date new address is received and updated
4. Contact Pre-reg Team to have the Bad Address FSC deleted

FSC S Self Pay

The Managed Insurance page should remain blank for new patients presenting for services that do not have insurance coverage. For existing patients whose coverage has expired at the time of services, an expiration date should be populated in all FSCs. The system will designate the patient payment responsibility during the charge entry process.
H) Commercial Insurance

- FSC 41 (Commercial Insurance) is used if the insurance carrier for the primary commercial coverage does not have a designated FSC number.

- FSC 44 (Commercial Insurance Secondary) should not be assigned before a primary insurance coverage FSC has been assigned.

Example 3.5

<table>
<thead>
<tr>
<th>Patient has 2 insurances without designated FSCs, should be registered:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary 41</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient has one insurance with a designated FSC, one without, should be registered:</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. Primary (Aetna Health Plan) 40 Secondary 44</td>
</tr>
</tbody>
</table>
I) Common Errors Which May Affect the Billing Process

- Space at the beginning of a line
- Use of punctuation in identification or group numbers, Use of dashes, hyphens, spaces asterisks
- The relationship to subscriber field left blank or answered incorrectly
- Subscriber Name (if different) enter name as it appears electronic on the validation tool or insurance card (when unable to validate coverage)
- Payer numbers used as identification or groups numbers
- Missing subscriber’s birthdate
- Missing subscriber’s sex
- Incomplete/inaccurate claims address

Billing Limitations

- Blue Cross/Blue Shield ⇒ 180 days
- Medicare/Basic Medicaid ⇒ 1 year
- Managed Medicaid ⇒ 90 days
- Managed Care ⇒ 90 days
In an effort to maintain the most relevant insurance card copies within the training documentation, we request the following (should you receive an insurance card that has not been incorporated and/or a newer version):

**EMR Users**

- The insurance card should be scanned into the EMR
- Document Type: Internal Other
- Create Helpdesk Ticket via email to **Centricity Business (IDX)** email [SOMCBhelp@rowan.edu](mailto:SOMCBhelp@rowan.edu)
- Include: Patient’s Name, Date of Birth (DOB), and Medical Record Number (MRN)

**Non-EMR Users**

- Copy the insurance card
- Create electronic version (scan to your RowanSOM email address)
- Create Helpdesk Ticket via email to **Centricity Business (IDX)** email [SOMCBhelp@rowan.edu](mailto:SOMCBhelp@rowan.edu)
- Attach Electronic version of the insurance card
<table>
<thead>
<tr>
<th>Section 2</th>
<th>Section Objectives</th>
</tr>
</thead>
</table>
| Blue Cross Blue Shield | • Understand the fundamental differences between Blue Cross and Blue Shield (BC/BS) coverage  
• Recognize various prefixes  
• Recognize various plan codes  
• Identify National BC/BS (aka: Out of Area BC/BS) |
A) Blue Cross/Blue Shield Overview

The Blue Cross and Blue Shield Association is the trade association for the oldest and largest group of health insurance companies in America. It is comprised of 44 independent, locally operated companies. These plans are located in 50 states, the District of Columbia, Puerto Rico and Internationally and offer a variety of insurance products to all segments of the population, including individuals, small businesses, seniors and large employer groups.

The Blue Cross plan pays for hospital charges and the Blue Shield plan pays physician charges. If the patient’s insurance card only indicates Blue Cross ask them if they have any additional insurance coverage to pay for the physician services.

The Alpha prefix and Blue Cross Blue Shield Plan Codes are the key elements used to identify and route the area claims. The prefix identifies the plan (by geographical area) or national account to which the member belongs.

- Blue Cross pays for Hospital services
- Blue Shield pays for Physician services

You must first determine the type of Blue Cross/ Blue Shield coverage the patient has and then select the appropriate IDX-FSC(s)

Participating Blue Cross/ BlueShield Plans
RowanSOM with the following Blue Cross/ BlueShield Plans

- Horizon Blue Cross Blue Shield of New Jersey
  Plan Codes 780/280

Blue Cross Blue Shield Federal Plan
The Federal Blue Cross Blue Shield Plan can be identified by the single alpha prefix character R and must be billed to the local Plan Horizon (BC/BS)
B) Central Certifications/National Accounts

- Out-of-Area Blues can be identified as any Blue Cross/Blue Shield Association other than:
  - Horizon Blue Cross Blue Shield of New Jersey
  - Federal Blue Cross Blue Shield Plan

**BC/BS HORIZON BLUE CROSS BLUE SHIELD**

In Mid November 2005, Horizon Blue Cross Blue Shield of New Jersey converted the Member Identification Number from the Social Security Number to a **15 character Unique Identification Number**. The new Identification Number will retain the three-letter Alpha-prefix which is required to ensure smooth claim submission. As existing patients present for care with cards, upon insurance verification; certified users must update the account reflecting the new information. Users, who do not physically view cards, be sure to ask the patient to read the complete ID number or contact Horizon at 800-624-1110.

The new ID format is described below.

- Position 1-3: Alpha Prefix
- Position 4: Numeric
- Position 5-7: Alpha Numeric
- Position 8-14: Numeric
- Position 15: will always be zero (0)

Attached you will find the updated Horizon Alpha Prefix Grids which includes Alpha prefixes for Local Unions. Horizon Blue Cross Blue Shield of New Jersey is one of the designated insurance carriers for the Local Unions.

Horizon Blue Cross Blue Shield of New Jersey members can be identified by the BC/BS Plan Codes 280/780 on their insurance identification cards. Patients presenting for service with Plan Codes 280/780 must be registered according to the attached Alpha Prefix Grid. Patients presenting with Plan Codes other than Horizon BC/BS of NJ 280/780
HORIZON NEW JERSEY BLUE SHIELD
NJ B/S 2ND

FSC 21
FSC 54

NAME J REGISTRAR
ID NUMBER YHC3HZN000045220
GROUP 00-82256
TYPE PC
EFFECTIVE DATE 11/01/05
BC/BS PLAN 280780
HORIZON BLUE CHOICE

FSC 156

NAME: R Hospitality
ID NUMBER: YHP3HZN00077880
GROUP: 00-82256
TYPE: PC
EFFECTIVE DATE: 11/01/16
BC/BS PLAN: 2901780

Managed Care Plans
Please refer to the Managed Care/ Medicare Section regarding the Horizon BC/BS Medicare Advantage Special Needs Plan
HORIZON NATIONAL BLUE SHIELD

FSC 24

**Product Type:** TRADITIONAL - NO SUITCASE  
**Alert Needed:** NO  
**Type of Alert:** N/A

**Product Type:** PPO, SUITCASE WITH PPO  
**Alert Needed:** NO  
**Type of Alert:** N/A

**Product Type:** POS - EMPTY SUITCASE  
**Alert Needed:** YES  
**Type of Alert:** AUTHORIZATION REQUIRED

**Product Type:** HMO - EMPTY SUITCASE  
**Alert Needed:** YES  
**Type of Alert:** AUTHORIZATION REQUIRED
FEDERAL BLUE CROSS BLUE SHIELD

FSC 21

[Image of a Federal Employee Program card with details]

©2013 Rowan University School of Osteopathic Medicine
Information Resources and Technology Clinical Systems Department

Centricity Business-Version 1
10/10/2013
## BC/BS Horizon – GRID

<table>
<thead>
<tr>
<th>Prefix</th>
<th>Plan Type</th>
<th>IDX-FSC</th>
<th>FSC Mnemonic</th>
<th>Telephone</th>
<th>Physician Claims Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>YHC, YHU, YHS, YHQ</td>
<td>Commercial</td>
<td>21</td>
<td>NJBS</td>
<td>800-624-1110</td>
<td>PO Box 1609 Newark, NJ 07101-1609</td>
</tr>
<tr>
<td>R, 8-Digits &amp; PPO Logo (Federal Employees)</td>
<td>Commercial</td>
<td>21</td>
<td>NJBS</td>
<td>800-624-1110</td>
<td>PO Box 656 Newark, NJ 07101-1609</td>
</tr>
<tr>
<td>FMA, FMR, NCH, YHF, YHN, HIF, HSG</td>
<td>Commercial</td>
<td>21</td>
<td>NJBS</td>
<td>800-624-4758</td>
<td>PO Box 247 Newark, NJ 07101-0247</td>
</tr>
<tr>
<td>NGM, DEH, DMM, DTM, DTP, NGM, GMM General Motors/Delphi Auto</td>
<td>Commercial</td>
<td>24</td>
<td>NBS</td>
<td>800-452-1396</td>
<td>PO Box 639 Newark, NJ 07101-0637</td>
</tr>
<tr>
<td>FMA, FMR Ford Motor Company</td>
<td>Commercial</td>
<td>21</td>
<td>NJBS</td>
<td>800-624-4758</td>
<td>PO Box 247 Dept V. Newark, NJ 07101-0247</td>
</tr>
<tr>
<td>ATT, AYA, LTI, AT&amp;T Avaya, Lucent Technology Members</td>
<td>Blue Choice</td>
<td>156</td>
<td>BC</td>
<td>800-624-1110</td>
<td>PO Box 728 Newark, NJ 07101-0728</td>
</tr>
<tr>
<td>YHD, YHG, YHP, YHH &amp; ALL other POS members</td>
<td>Blue Choice</td>
<td>156</td>
<td>BC</td>
<td>800-624-1110</td>
<td>PO Box 820 Newark, NJ 07101-0820</td>
</tr>
<tr>
<td>NJX – NJ State Health Benefit Program</td>
<td>Commercial</td>
<td>21</td>
<td>NJBS</td>
<td>800-624-1110</td>
<td>PO Box 820 Newark, NJ 07101-0820</td>
</tr>
</tbody>
</table>
## BC/BS Horizon – GRID

<table>
<thead>
<tr>
<th>Prefix</th>
<th>Plan Type</th>
<th>IDX-FSC</th>
<th>FSC Mnemonic</th>
<th>Telephone</th>
<th>Physician Claims Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>JGK</td>
<td>(EPO &amp; EPO Plus)</td>
<td>21</td>
<td>NJBS</td>
<td>800-624-1110</td>
<td>PO Box 1609 Newark, NJ 07101-1609</td>
</tr>
<tr>
<td>NHC, HSG, HWW, HWA</td>
<td>Commercial</td>
<td>21</td>
<td>NJBS</td>
<td>800-624-1110</td>
<td>PO Box 1609 Newark, NJ 07101-1609</td>
</tr>
<tr>
<td>JGA, JGD, JGG, JGF</td>
<td>(Consumer Directed Healthcare)</td>
<td>21</td>
<td>NJBS</td>
<td>800-624-1110</td>
<td>PO Box 1609 Newark, NJ 07101-1609</td>
</tr>
<tr>
<td><strong>Local Union</strong></td>
<td><strong>TWP, ZJP</strong></td>
<td><strong>21</strong></td>
<td><strong>NJBS</strong></td>
<td><strong>800-624-1110</strong></td>
<td><strong>PO Box 1301</strong> Neptune, NJ 07754</td>
</tr>
<tr>
<td><strong>Local Union</strong></td>
<td><strong>HUF, HWX</strong></td>
<td><strong>24</strong></td>
<td><strong>NBS</strong></td>
<td><strong>800-452-1396</strong></td>
<td><strong>PO Box 820</strong> Newark, NJ 07101-0820</td>
</tr>
<tr>
<td>YHM,YHO</td>
<td>HMO</td>
<td>74</td>
<td>MGP</td>
<td>800-624-1110</td>
<td>PO Box 1609 Newark, NJ 07101-1609</td>
</tr>
<tr>
<td>YHT,YKB,YKD, YKN,YHV,YKI,YKO, YKM, YKK</td>
<td>Medicare Advantage</td>
<td>874</td>
<td>HOMA</td>
<td>800-624-1110</td>
<td>PO Box 1609 Newark, NJ 07101-1609</td>
</tr>
<tr>
<td>YHR, YHW</td>
<td>Medicare Supplement</td>
<td>29</td>
<td>N65</td>
<td>800-624-1110</td>
<td>PO Box 1184 Newark, NJ 07101-1184</td>
</tr>
<tr>
<td>Horizon NJ Health (NJMA)</td>
<td>NJ Medical Assistance</td>
<td>96</td>
<td>MHP</td>
<td>877-765-4325</td>
<td>PO Box 7117 London, KY 40742</td>
</tr>
<tr>
<td><strong>Section 3</strong></td>
<td><strong>Managed Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Section Objectives</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Understand the fundamental differences between the three types of managed care products</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Recognize what is required to complete registration for patients with managed care coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A) Types of Managed Care

1. HMO - Health Maintenance Organization

- Members must select a ‘primary care physician’ who is responsible for coordinating all medical care delivered including:
  - Complete medical record and history.
  - Referrals to any necessary specialists, hospitals and labs.

- Members pay a co-pay for physician services and hospital emergency room services. There are no deductibles or claim forms.

- Members have the least amount of freedom in choosing physicians.

- Members have the least out-of-pocket expense.

<table>
<thead>
<tr>
<th>Example 5.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keystone Healthplan East</td>
</tr>
<tr>
<td>United Healthcare Group Plans</td>
</tr>
</tbody>
</table>
2. POS - Point of Service

- Members can receive in-network (higher) benefit levels by having medical care coordinated by a primary care physician as described under ‘HMO’.

- Members have the option to go outside the network, i.e., not access a primary care physician for medical services and still receive benefit coverage (out-of-network benefits). With this option the member utilizes their out-of-network benefits. The member incurs a higher out of pocket expense. They are subject to deductibles and coinsurance (i.e. a percentage of the bill).

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilize PCP</td>
<td>May use any provider</td>
</tr>
<tr>
<td>Higher benefit level</td>
<td>Lower benefit level</td>
</tr>
<tr>
<td>Lower Out-of-Pocket</td>
<td>Higher Out-of-Pocket</td>
</tr>
<tr>
<td>Expenses</td>
<td>Expenses</td>
</tr>
<tr>
<td>Collect co-payment</td>
<td></td>
</tr>
</tbody>
</table>

- Members must utilize laboratories and radiology departments within network.

Example 5.2

Aetna Managed Choice /(EPO)
3. PPO - Preferred Provider Organization

- Members have the freedom to access in-network providers or out-of-network providers.

- Unlike HMOs, use of a primary care physician is not necessary. Higher benefit levels are received simply by utilizing in-network providers.

- Deductibles, co-insurance and co-pay may apply to both in-network and out-of-network utilization.

- Members have the most freedom in choosing physician.

- Members have higher out-of-pocket expenses.

- Claims address may be different for in-network and out-of-network benefits.

Example 5.3

| Aetna Open Choice | Maxnet | Cigna PPO | PHCS |

4. Third Party Administrator (TPA)

Third Party Administrators serve as PPO Networks. TPAs provide administrative services to small employer groups and/or self-funded Health Organizations; they re-price the claims to ensure the best payment rate. Benefit limitations may apply. When the patient’s insurance card list multiple networks, you must confirm with the insurance carrier which network is applicable for the services rendered by RowanSOM.

General Managed Care Buzz Words

- MAGNACARE
- MAXNET
- COPAY
- PCP

- CHOICE
- PHCS
- NETWORK
- HMO, PPO, POS

- DEVON
- PREFERRED CARE
- INTERGROUP
- EC (Elect Choice)
- MC (Managed Choice)
5. Medicare Managed Care Plans

These plans replace Medicare. Once a patient has selected a Medicare replacement plan, the patient must abide by the rules and guidelines of the new plan. These plans replace Medicare Part A and Part B. Patients cannot have coverage for both. You must expire Medicare coverage if patient was originally registered as such. These plans offer HMO and POS coverage. A referral may be required to obtain services.

- Aetna Golden Medicare (ME prefix)
- Amerihealth 65
- Personal Choice 65
- First Priority 65  (non-participating)
- PHS HealthNet Smart Choice   (non-participating)
- Keystone 65
- Horizon Medicare Blue (NJ BC/BS)/
- Horizon Medicare Blue (NJ BC/BS Special Needs Plan)  
  dually eligible no copay collection required
- Bravo Healthcare
- United Healthcare Group Medicare Advantage (non-participating)
- Uniformed Services (SVCS) Family Health Plan
6. Medicaid Managed Care (Health Choices)

These plans are Medical Assistance Replacement Plans. Do not register the patient with both Health Choices and Medical Assistance. These plans require a referral for services rendered. Health Choices patients without cards can be registered using the Eligibility Verification System, via the telephone, HDX or point of service machines. This coverage must be verified at each visit.

- United Healthcare Community Plan - FSC 451
  *formerly Americhoice*

- Horizon NJ Health - FSC 96

- Amerigroup - FSC 116 - *Used in BAR Group #6 only*

- Healthfirst NJ - *(non-participating)*
  (Patients should be advised to contact their plan for participating provider(s))

- Group #4 Users – enter the patient’s NJMA insurance only
B) Secondary Managed Care

- Use designated FSC first for all contracted payers
- FSC 41 is used if the insurance carrier for the primary coverage does not have a designated FSC number.
- FSC 44 should not be assigned before a primary insurance coverage FSC has been assigned.

Example 3.5

Patient has 2 insurances with designated FSCs, should be registered:

e. g. Primary (Aetna Health Plan) 48 Secondary (Keystone) 452

Patient has 1 insurance with a designated FSC or Grouping Restriction FSC, 1 without, should be registered:

e. g. Primary (Aetna Health Plan) 48 Secondary 44

Patient has 2 insurances without designated FSCs, should be registered:

e. g. Primary 41 Secondary 44
FSC 48 Aetna HMO

FSC 40 Aetna (Non-HMO)

ID Numbers are key in identifying the correct FSC
As a third party Administrator (TPA), AmeriHealth Administrators provides health benefits claims administration and an array of other outsourcing services to self-insured companies nationwide. These TPA services include nationwide health care networks, medical management programs, and COBRA, FSA HRA, HIPAA, and wellness programs. 1-800-480-5032
Note: Kennedy Health System Employees with Cigna Care have a lower co-pay amount when receiving services at RowanSOM. (Carefully review the patient card for the Kennedy Health System logo).
KEYSTONE HEALTH PLAN EAST
Keystone Health Plan East (KHPE)

FSC 452

FSC 852
MAGNACARE

FSC 189

Eligibility: To verify eligibility, benefits, and claim information, please call MagnaCare at 800-123-4567

Pre-certification: Contact MagnaCare at 888-123-4567 to obtain authorization for all in-patient Admissions, Out-patient services, MRI/MRA, CT/PET/SPECT scans. Failure to pre-certify may result in a reduction or denial of benefits.

Co-payments:
- $25.00 Office Visit
- $50.00 Specialist Office Visit
- $100.00 Emergency Room

Claim Forms: Submit Medical & Hospital claims electronically via Emdeon (Payor#11305)
Mail completed claim forms to:
MAGNACARE
P.O. BOX 1001
GARDEN CITY, NY 11530

SUBMIT CLAIMS ELECTRONICALLY VIA EMDEON (Payor#11305)
Possession of this card does not certify eligibility or guarantee payment.
There are several variations of this ID card, depending upon the payor and/or employer.
OLEFORD HEALTH PLANS

FSC 151

ATLANTIC EXPRESS
MEBER J. Q. PUBLIC
ID 628325301
GRP: 0000-11-000

© 2013 Rowan University School of Osteopathic Medicine
Information Resources and Technology Clinical Systems Department
Centricity Business-Version 1
10/10/2013
FSC 47
UNIFORMED SVCS FAMILY HLTH PLN

FSC 760

Member ID Number: 112333455
Group Number: A08JUN
Rx $3
Copay: OV$5 ER$25
Generic
Brand

Member

If this is a life-threatening emergency, go to the nearest emergency room.
For immediate treatment and notify your Primary Care Manager.
Routine and Urgent Care call your Primary Care Manager.
Eligibility, claims or benefit questions, call Customer Service at
800-241-4840
Pharmacy information call Maxor Plus at: 800-687-0707
Maxor mail order: 866-400-5459

Providers: For pre-certification or admission verification call: 866-299-0933
Submit Claims to: US Family Health Plan
PO Box 630745
Birmingham, AL 35283-0745
All routine care must be performed by PCP and all Specialty Care
must be referred and authorized

PROVIDER – DO NOT BILL TRICARE OR MEDICARE
CHAMPVA (disabled beneficiaries)

FSC 41

Eff: 01/01/07
Richard Serviceman
ID #: 123456789
FSC 350

The Saint Barybaras System Health Plan

Group Number: 060110
Member ID Number DOB Gender
Mary Smith 111122222 1/0/67 F

Copays:
- Primary Care $15
- Specialist $25
- Emergency Room Copay $50
- Rx: Retail Generic $5 Formulary Brand $30 Non Formulary Brand $45

Guardian Dental Plan Policy Number: 02141302

The Qualicare PPO Network

Group Number: 452512
Member ID Number DOB Gender
Mary Smith 111122222 1/0/67 F

Copays:
- Primary Care/OBGYN/OV $20
- Specialist/OV $30
- Emergency Room Copay $50
- Rx: Retail Generic $15 Formulary Brand $30 Non Formulary Brand $45

Guardian Dental Plan Policy Number: 02141302

The Qualicare PPO Network
Section 4

Medicare and Medicare Managed Care

Section Objectives

- Understand the difference between Traditional and Railroad Medicare
- Identify Medicare replacement plans
- Understand Medicare as a secondary payer
A) Medicare

The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

**Medicare Part A**
Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care.

**Medicare Part B**
Medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A.

**Traditional Medicare Alpha Suffixes**

- A  - Wage earner (Old age or disability)
- B  - Aged wife
- B1 - Husband
- B2 - Young wife (entitled child in her care)
- B3 - Second claimant
- B4 - Second claimant
- B5 - Second claimant
- B6 - Divorced wife
- B7 - Third claimant
- B8 - Third claimant
- B9 - Second claimant (combined AB payment – wage earner and spouse)
- C1 - Child (youngest)
- C2 - Second youngest child
- D  - Aged widow
- D1 - Widower
- D2 - Second claimant
- D3 - Second claimant
- D4 - Remarried widow (60 years of age or older)
- D5 - Remarried widow (62 years of age or older)
- D6 - Surviving divorced wife
- D7 - Second claimant
- E  - Mother (widow)
- E1 - Surviving divorced mother
- E2 - Second claimant
Traditional Medicare Alpha Suffixes cont.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E3</td>
<td>Second claimant</td>
</tr>
<tr>
<td>E4</td>
<td>Widower</td>
</tr>
<tr>
<td>E7</td>
<td>Third claimant</td>
</tr>
<tr>
<td>F1</td>
<td>Father</td>
</tr>
<tr>
<td>F2</td>
<td>Mother</td>
</tr>
<tr>
<td>F3</td>
<td>Stepfather</td>
</tr>
<tr>
<td>F4</td>
<td>Stepmother</td>
</tr>
<tr>
<td>F5</td>
<td>Adopting Father</td>
</tr>
<tr>
<td>F6</td>
<td>Adopting Mother</td>
</tr>
<tr>
<td>F7</td>
<td>Second alleged father</td>
</tr>
<tr>
<td>F8</td>
<td>Second alleged mother</td>
</tr>
<tr>
<td>HB</td>
<td>Aged wife</td>
</tr>
<tr>
<td>HB1</td>
<td>Husband</td>
</tr>
<tr>
<td>HB2</td>
<td>Young wife</td>
</tr>
<tr>
<td>HB6</td>
<td>Divorced wife</td>
</tr>
<tr>
<td>HC</td>
<td>Child</td>
</tr>
<tr>
<td>J1</td>
<td>Primary (less that 3 QC’s and entitled to HIB)</td>
</tr>
<tr>
<td>J2</td>
<td>3 or more QC’s and entitled to HIB</td>
</tr>
<tr>
<td>J3</td>
<td>Less that 3 QC’s and not entitled to HIB</td>
</tr>
<tr>
<td>J4</td>
<td>3 or more QC’s and not entitled to HIB</td>
</tr>
<tr>
<td>K1</td>
<td>Wife’s (less that 3 QC’s and entitled to HIB)</td>
</tr>
<tr>
<td>K2</td>
<td>3 or more QC’s and entitled to HIB</td>
</tr>
<tr>
<td>K3</td>
<td>Less than 3 QC’s and not entitled to HIB</td>
</tr>
<tr>
<td>K4</td>
<td>3 or more QC’s and not entitled to HIB</td>
</tr>
<tr>
<td>LM</td>
<td>Coal miner</td>
</tr>
<tr>
<td>LW</td>
<td>Widow or coal miner</td>
</tr>
<tr>
<td>LB</td>
<td>Wife of coal miner</td>
</tr>
<tr>
<td>LX</td>
<td>Disabled wife of coal miner</td>
</tr>
<tr>
<td>L1</td>
<td>Child of coal miner (L2, L3, L4, etc.)</td>
</tr>
<tr>
<td>M</td>
<td>Uninsured (not entitled to HIB but qualified for SMIB)</td>
</tr>
<tr>
<td>M1</td>
<td>Uninsured (qualifies for HIB but requests only SMIB)</td>
</tr>
<tr>
<td>MA</td>
<td>Spouse (male or female) of live employee-age of disability</td>
</tr>
<tr>
<td>W</td>
<td>Disabled widow</td>
</tr>
<tr>
<td>W2</td>
<td>Disabled widow (second claimant)</td>
</tr>
<tr>
<td>W3</td>
<td>Disabled widower (second claimant)</td>
</tr>
<tr>
<td>W4</td>
<td>Disabled widow</td>
</tr>
<tr>
<td>W5</td>
<td>Disabled widower</td>
</tr>
<tr>
<td>W6</td>
<td>Disabled surviving divorced wife</td>
</tr>
<tr>
<td>W7</td>
<td>Disabled surviving divorced wife (second claimant)</td>
</tr>
<tr>
<td>W8</td>
<td>Disabled surviving divorced wife</td>
</tr>
<tr>
<td>W9</td>
<td>Disabled widow</td>
</tr>
</tbody>
</table>
Railroad Retirement Medicare Alpha Prefixes

A    -  Retired railroad worker (annuitant)
H    -  Retired worker on a pension
JA   -  Survivor (joint annuitant) an employee who is receiving a reduced annuity in order to guarantee payment of his widow
MA   -  Spouse of annuitant
MH   -  Spouse of pensioner
PA   -  Parent of a deceased annuitant
PD   -  Parent of a deceased pensioner
WA   -  Widow or widower of annuitant who is over 60 years of age
WCA  –  Widow with a child in her care or child alone of an annuitant
WCD  –  Widow with a child in her care, or a child alone of an employee
WCH  –  Widow with a child in her care, or a child alone of a pensioner
WD   -  Widow or widower of an employee who is over 60 years of age
WH   -  Widow or widower of a pensioner
B) Medicare as Secondary Payer Questionnaire (MSP)

The Medicare Questionnaire will read as follows:

The basic Questionnaire will consist of thirteen basic fields in the insurance follow up questions. They are as follows:

1. Certificate Number
2. Subscriber’s Name (if different)
3. Effective Date
4. Expiration Date
5. Working Patient either full or part time
6. Covered under group insurance
7. Spouse is working either full or part time
8. Patient covered under spouse group insurance
9. Is service due to an accident of any kind
C) Medicare as Secondary Payer Questionnaire (MSP) continued

10. Type of accident
11. End Stage Renal Disease (aka: ESRD)
12. Date dialysis began
13. Does patient have Federal Black Lung card
14. Medigap form signed
# Medicare Secondary Payer Quick Reference Guide

<table>
<thead>
<tr>
<th>If You</th>
<th>Condition</th>
<th>Pays First</th>
<th>Pays Second</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are age 65 or older &amp; covered by a group health plan because you are</td>
<td>- The employer has less than 20 employees</td>
<td>Medicare</td>
<td>Group Health Plan</td>
</tr>
<tr>
<td>working or are covered by a group health plan of a spouse of any age</td>
<td>- The employer has 20 or more employees</td>
<td></td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have an employer retiree plan and are age 65 or older or disabled</td>
<td>- Eligible for Medicare</td>
<td>Medicare</td>
<td>Retiree coverage</td>
</tr>
<tr>
<td>age 65 or older or disabled age 65 or older</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are disabled &amp; covered by a large group health plan from you work,</td>
<td>- The employer has less than 100 employees</td>
<td>Medicare</td>
<td>Group health plan</td>
</tr>
<tr>
<td>or from a family member who is working</td>
<td>- The employer has 100 or more employees</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have End-Stage Renal Disease (permanent Kidney Failure) &amp; group</td>
<td>- First 30 months of eligibility or entitlement to Medicare</td>
<td>Group health</td>
<td>Medicare</td>
</tr>
<tr>
<td>health plan coverage (including a retirement plan) or COBRA</td>
<td>- After 30 months</td>
<td>plan or</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>COBRA</td>
<td></td>
</tr>
</tbody>
</table>
### Medicare Secondary Payer Quick Reference Guide

<table>
<thead>
<tr>
<th>If You</th>
<th>Condition</th>
<th>Pays First</th>
<th>Pays Second</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are covered under worker's compensation because of a job related illness or injury</td>
<td>Eligible for Medicare</td>
<td>Worker's compensatio for W/C injuries</td>
<td>Medicare</td>
</tr>
<tr>
<td>Have black lung disease &amp; covered under the Federal Black Lung Programs</td>
<td>Eligible for Federal Black Lung Program</td>
<td>Federal Black Lung Program</td>
<td>Medicare</td>
</tr>
<tr>
<td>Have been in an accident where no-fault or liability insurance is involved</td>
<td>Eligible for Medicare</td>
<td>No-Fault or Liability insurance, for accident related injuries</td>
<td>Medicare</td>
</tr>
<tr>
<td>Are 65 or older or disabled &amp; covered by Medicare &amp; Cobra</td>
<td>Eligible for Medicare</td>
<td>Medicare</td>
<td>Cobra</td>
</tr>
</tbody>
</table>
D) Medicare Managed Care

These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare + Choice
A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease.

Medicare HMO
Medicare HMO is an HMO that has contracted with the federal government under the Medicare+Choice program to provide health benefits to persons eligible for Medicare that choose to enroll in the HMO, instead of receiving their benefits and care through the traditional fee for service Medicare program

Impact to the Registration Process
Medicare & Medicare Replacement plans cannot be effective at the same time. If the patient was originally registered with Traditional Medicare/Railroad Medicare this coverage must be expired when entering the Medicare replacement plan
FSC 81
FSC 86

Medicare Part B
Medicare Part A

FSC 88
Travelers Medicare Part B (Railroad Retirement Board)
Medicare Part A
AMERIHEALTH 65 MEDICARE ADVANTAGE

FSC 877
Amerihealth 65

This plan replaces Medicare benefits.
KEYSTONE 65 MEDICARE ADVANTAGE

FSC 852
Keystone Health Plan East
(Keystone 65)

This plan replaces Medicare benefits.
This plan replaces Medicare benefits.
AETNA MEDICARE ADVANTAGE HMO
AETNA MEDICARE ADVANTAGE PPO

FSC 848
FSC 840

This plan replaces Medicare benefits.
BRAVO HEALTH MEDICARE ADVANTAGE

FSC 851

Please present this card for all medical and prescription drug services.

- Customer Service: 699-467-3433
- TTY: 609-864-2561
- Preauthorization: 215-866-8336
- Administration: 215-866-8336

All hospitalization must be authorized by Bravo Health by calling the
number listed above. The only exception is for emergency care and
out-of-area urgent care and renal dialysis.

- Medical Claims:
  - Bravo Health: Medicare Health Solutions, Inc.
  - PO Box 4433
  - Baltimore, MD 21223

- Pharmacy Claims:
  - PO Box 14711
  - Lexington, KY 40512
Medigap vs. Employer Supplement Coverage

Medigap Coverage (patient pays for coverage):
If a Medicare patient has supplemental insurance that is not offered by a former employer to help cover non-reimbursable charges, deductibles, and co-insurance, this insurance is called medigap.

Employer Supplemental Coverage (employer pays for coverage):
If a Medicare patient has supplemental insurance offered by an employer to employees, or plans offered by Labor Organizations to members or former members, this insurance is considered employer supplemental coverage.
Secondary to Medicare

FSC 29
NJ 65 SPECIAL

Horizon Blue Cross Blue Shield of New Jersey

SUBSCRIBERS NAME

IDENTIFICATION NO: GROUP NO:
YHR58345144 NONGRP

BS/BC PLAN: 780/280
MEDIGAP
Secondary to Medicare

FSC 30
Blue Shield
PA 65 SPECIAL

SUBSCRIBERS NAME

IDENTIFICATION NO: GROUP NO:
QCW123456789 533324D

BS/BC PLAN: 865/362
65 SPECIAL PLAN H

SUBSCRIBERS NAME

IDENTIFICATION NO: GROUP NO:
QCS123456789 90000A

BS/BC PLAN: 865/362
SECURITY 65 PLAN C
Tricare For Life (Secondary To Medicare)

FSC 50

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>MI</th>
<th>FIRST NAME</th>
<th>SSO</th>
<th>DOB</th>
<th>GENDER</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>RECORD LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAPLE</td>
<td>PA</td>
<td>L</td>
<td>32</td>
<td>222-33-531</td>
<td>M</td>
<td>19500907</td>
<td>WPS TRICARE FOR LIFE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Medicare Supplemental-** Patients presenting with Tricare Secondary to Medicare must be registered in COM INS AFT MEDICARE

- **Select address from Commercial Insurance Dictionary**
  - WPS TRICARE FOR LIFE
AARP Medigap

FSC 50

Insured Member
Susan T Smith

Membership No
40236552012
000824
medicare supplement coverage

Insured Member
John Q Public
Membership No.
05632012511

Medicare Supplement coverage
## Section 5: Medical Assistance and Health Choices

<table>
<thead>
<tr>
<th>Medical Assistance and Health Choices</th>
<th>Section Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Understand Medical Assistance</td>
<td></td>
</tr>
<tr>
<td>- Understand Health Choices</td>
<td></td>
</tr>
<tr>
<td>- Understand and comply with policy</td>
<td></td>
</tr>
<tr>
<td>requirements</td>
<td></td>
</tr>
</tbody>
</table>

© 2013 Rowan University School of Osteopathic Medicine
Information Resources and Technology Clinical Systems Department

Centricity Business-Version 1
10/10/2013
A) New Jersey (NJ) Medical Assistance Program

As of 06/01/06 Burlington, Camden and Gloucester Counties started a pilot program for the new State of New Jersey Health Benefits. Patients eligible for Medicaid who live in these counties will no longer receive the monthly paper card. They will receive a permanent plastic card displayed above. (As of 09/01/06, no paper cards will be issued.)

The first three positions of the CCN or Control Number will always be “777”, followed by an eleven position non-intelligent enumeration, followed by a two-position issuance number of “01” to indicate this is the first HBID card. In the event the beneficiary requires a replacement card, the CCN will remain the same but the issuance number will increment to “02” indicating another card has been issued.

A striking difference from the paper card is the lack of any eligibility and enrollment information on the card itself. There is no Medicaid ID and coverage period listed for the beneficiary; therefore, this card cannot be used as proof of eligibility. Users are required to check for the Medicaid ID number and enrollment information. The information may be obtained by calling 800-676-6562 to verify eligibility. **After verify eligibility users must enter the 10 digit Identification number and 2 digit person number a total of 12 characters within the identification number field.**

NJ Medicaid & Managed Care

In 1995, New Jersey Medicaid began moving Medicaid clients from a traditional fee-for-service health insurance program, in which healthcare providers bill Medicaid directly, into managed care. Under managed care, clients enroll in an HMO, which manages their healthcare and offers special services in addition to the benefits to which Medicaid clients are entitled.

Four Health Maintenance Organizations (HMOs) participate in this program with NJ FamilyCare/Medicaid. They are:

AMERIGROUP NJ

Healthfirst NJ

Horizon NJ Health

UnitedHealthcare Community Plan

Through managed care, New Jersey Medicaid believes clients have better access to healthcare providers than they do through Medicaid's traditional fee-for-service health insurance program. Health Maintenance Organizations are also able to provide a comprehensive package of preventive health services that combined with the full range of Medicaid benefits allows for the best healthcare possible.

Providers and others who are interested can view New Jersey Medicaid’s current Managed Care Contract. (PDF File)
## Medical Assistance Customer Centers - MACCs

<table>
<thead>
<tr>
<th>MACC OFFICE</th>
<th>DIRECTOR &amp; PHONE#</th>
<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(01) <strong>ATLANTIC</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>609-561-7569</strong> Fax: 609-567-0572</td>
<td>Augusta Bldg 852 South White Horse Pike Hammonton, NJ 08037-2018</td>
</tr>
<tr>
<td>(06) <strong>CUMBERLAND</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>609-561-7569</strong> Fax: 609-567-0572</td>
<td></td>
</tr>
<tr>
<td>(04) <strong>CAMDEN</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>856-614-2870</strong> Fax: 856-614-2575</td>
<td>One Port Center, 2 Riverside Dr. Suite 401 Camden, NJ 08103-1070</td>
</tr>
<tr>
<td>(03) <strong>BURLINGTON</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>609-561-7569</strong> Fax: 609-567-0572</td>
<td></td>
</tr>
<tr>
<td>(08) <strong>GLOUCESTER</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>609-561-7569</strong> Fax: 609-567-0572</td>
<td></td>
</tr>
<tr>
<td>(11) <strong>MERCER</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>609-561-7569</strong> Fax: 609-567-0572</td>
<td></td>
</tr>
<tr>
<td>(17) <strong>SALEM</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>609-561-7569</strong> Fax: 609-567-0572</td>
<td></td>
</tr>
<tr>
<td>(07) <strong>ESSEX</strong></td>
<td>Stewart Klaus, Director Phone: <strong>973-648-3700</strong> Fax: 973-642-6468</td>
<td>153 Halsey St 4th Floor Newark, NJ 07102-2807</td>
</tr>
<tr>
<td>(09) <strong>HUDSON</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>609-561-7569</strong> Fax: 609-567-0572</td>
<td></td>
</tr>
<tr>
<td>(13) <strong>MONMOUTH</strong></td>
<td>Gregory Karlin, Director Phone: <strong>732-863-4400</strong> Fax: 732-863-4450</td>
<td>100 Daniels Way 1st Floor Freehold, NJ 07728-2668</td>
</tr>
<tr>
<td>(12) <strong>MIDDLESEX</strong></td>
<td>Evangelia Stamboulis, Director Phone: <strong>732-863-4400</strong> Fax: 732-863-4450</td>
<td></td>
</tr>
<tr>
<td>(15) <strong>OCEAN</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>609-561-7569</strong> Fax: 609-567-0572</td>
<td></td>
</tr>
<tr>
<td>(10) <strong>HUNTERDON</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>609-561-7569</strong> Fax: 609-567-0572</td>
<td></td>
</tr>
<tr>
<td>(18) <strong>SOMERSET</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>609-561-7569</strong> Fax: 609-567-0572</td>
<td></td>
</tr>
<tr>
<td>(20) <strong>UNION</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>609-561-7569</strong> Fax: 609-567-0572</td>
<td></td>
</tr>
<tr>
<td>(16) <strong>PASSAIC</strong></td>
<td>Robert Dueben, Director Phone: <strong>973-977-4077</strong> Fax: 973-684-8182</td>
<td>100 Hamilton Plaza 5th Floor Paterson, NJ 07505-2109</td>
</tr>
<tr>
<td>(02) <strong>BERGEN</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>609-561-7569</strong> Fax: 609-567-0572</td>
<td></td>
</tr>
<tr>
<td>(14) <strong>MORRIS</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>609-561-7569</strong> Fax: 609-567-0572</td>
<td></td>
</tr>
<tr>
<td>(19) <strong>SUSSEX</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>609-561-7569</strong> Fax: 609-567-0572</td>
<td></td>
</tr>
<tr>
<td>(21) <strong>WARREN</strong></td>
<td>Patricia Dana, Acting Director Phone: <strong>609-561-7569</strong> Fax: 609-567-0572</td>
<td></td>
</tr>
</tbody>
</table>

*Francine Cirelly, DO

*Philip Malvin, DO

*John Sawicki, DO

* Denotes Home Office

### Eligibility and Service Manuals

In order for you to find the most up-to-date version of the many Medicaid Eligibility & Service Manuals, we have changed this DMAHS web page.

Instead of searching through a long list here, only to find a chapter of the Code which may not yet have been updated on our DMAHS website, we are now providing a link directly to the actual host site for the New Jersey Administrative Code (N.J.A.C.), which is LexisNexis.
The New Jersey Eligibility and Service Manuals are hosted by the LexisNexis free public access site for the N.J.A.C.

**Here are instructions to the LexisNexis site:**
To browse the Eligibility and Service manuals, click on the link below (a new window will open). Please note that pop-ups must be enabled to view the manuals.

After agreeing to the Terms and Conditions, click on the N.J.A.C. folder on the left, then click Title 10.

From here you can select the chapter, subchapter and section of the DMAHS rule that you would like to view.

www.lexisnexis.com/hottopics/njcode

**HMOs**

**HMOs Currently Under Contract and Providing Medicaid Managed Care Services in New Jersey**

**AMERIGROUP New Jersey, Inc.**

<table>
<thead>
<tr>
<th>Provider Relations Phone Number</th>
<th>1-800-454-3730</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Services Phone Number</td>
<td>1-800-600-4441</td>
</tr>
<tr>
<td>TDD Number</td>
<td>1-800-852-7899</td>
</tr>
</tbody>
</table>

Atlantic
Bergen
Burlington
Camden
Cape May
Cumberland
Essex
Gloucester
Hudson
Hunterdon
Mercer
Middlesex
Monmouth
Morris
Ocean
Passaic
Somerset
Sussex
Union
Warren
### Healthfirst NJ

1 Washington Street  
Newark, New Jersey 07102

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations Phone Number</td>
<td>1-866-889-2523</td>
</tr>
<tr>
<td>Member Services Phone Number</td>
<td>1-888-464-4365</td>
</tr>
<tr>
<td>TDD Number</td>
<td>1-800-852-7897</td>
</tr>
</tbody>
</table>

*Patient should be advised to contact their plan for participating provider(s)*

### Horizon NJ Health

210 Silvia, Street  
Trenton, New Jersey 08628

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations Phone Number</td>
<td>1-800-682-9091</td>
</tr>
<tr>
<td>Member Services Phone Number</td>
<td>1-877-765-4325</td>
</tr>
<tr>
<td>TDD Number</td>
<td>1-800-654-5505</td>
</tr>
</tbody>
</table>

Atlantic  
Bergen  
Burlington  
Camden  
Cape May  
Cumberland  
Essex  
Gloucester  
Hudson  
Hunterdon  
Mercer  
Middlesex  
Monmouth  
Morris  
Ocean  
Passaic  
Salem  
Somerset  
Sussex  
Union  
Warren
UnitedHealthcare Community Plan

Atlantic
Bergen
Burlington
Camden
Cape May
Cumberland
Essex
 Gloucester
Hudson
Hunterdon
Mercer
Middlesex
Monmouth
Morris
Ocean
Passaic
Salem
Somerset
Sussex
Union
Warren

1-888-362-3368
1-800-941-4647
1-800-943-4647
1-800-852-7897

New Jersey Mental HealthCareS

Who Cares? We Do!

NJMentalHealthCareS is New Jersey's mental health information and referral service. Our team of mental health professionals use their experience and understanding of the mental health system to connect you to the information and services you need.

Call Today:
866-202-HELP (8375)
TTY: 973-508-6394

E-mail: help@mentalhealthcare.org

We are available Monday through Friday, 8 A.M. to 8 P.M. (EST).
Name, phone number, and message will be called your local public mental health provider.

If you are having an emotional crisis, click here to find your local emergency screening center which is available 24 hours a day, 7 days a week.

© 2013 Rowan University School of Osteopathic Medicine
Information Resources and Technology Clinical Systems Department

Centricity Business-Version 1
10/10/2013
N.J. MED ASSISTANCE
WELFARE AFTER MEDICARE

FSC 101
FSC 102

State of New Jersey
Health Benefits Identification Card

Department of Human Services
Division of Medical Assistance and Health Services

CCN: 7770000000001201
John Doe
null
NAME: NJ Medical Assistance (NJMA)
ID NUMBER: Refer to Card
CCN: 777000000001201
TYPE: FAMILY
EFFECTIVE DATE: 09/01/106
BC/BS PLAN: 280780