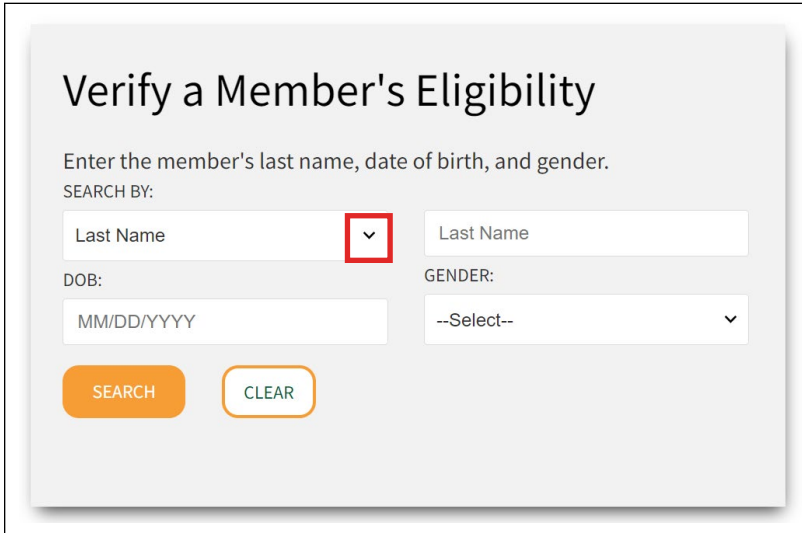


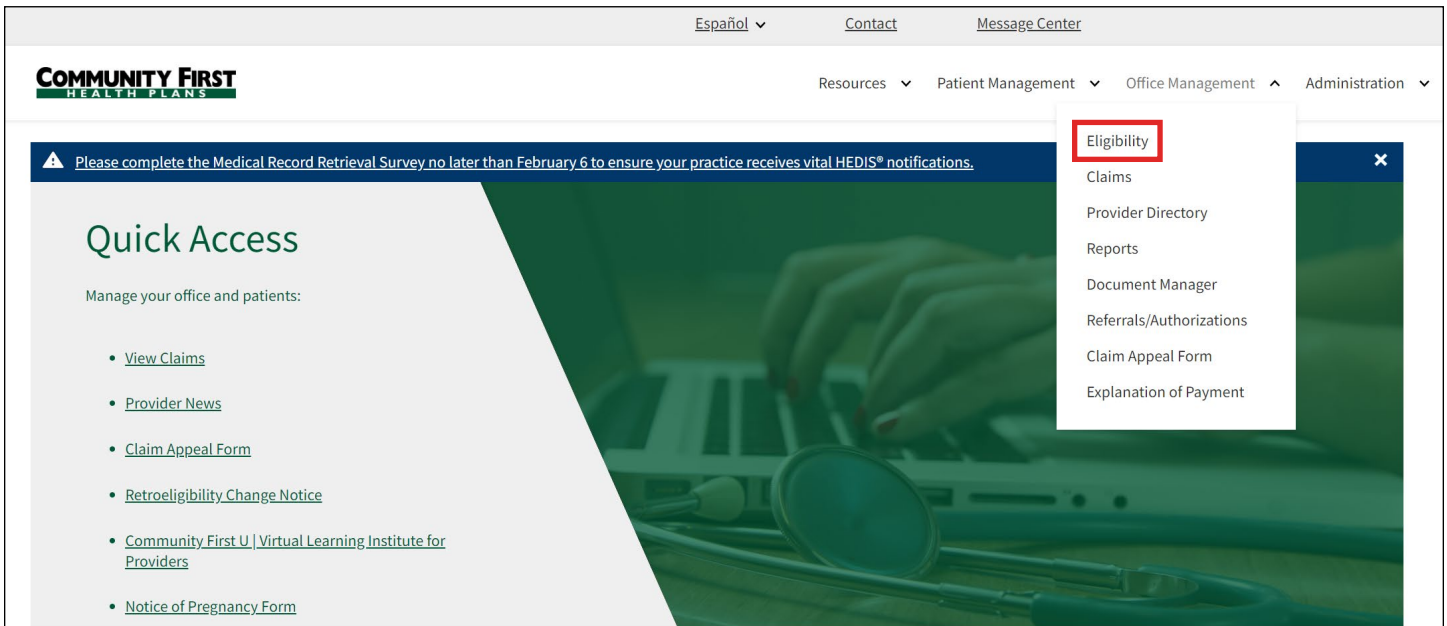
Verifying Member Eligibility

To verify Member eligibility, use the **quick search eligibility screen** on the bottom of the Provider Portal home page.

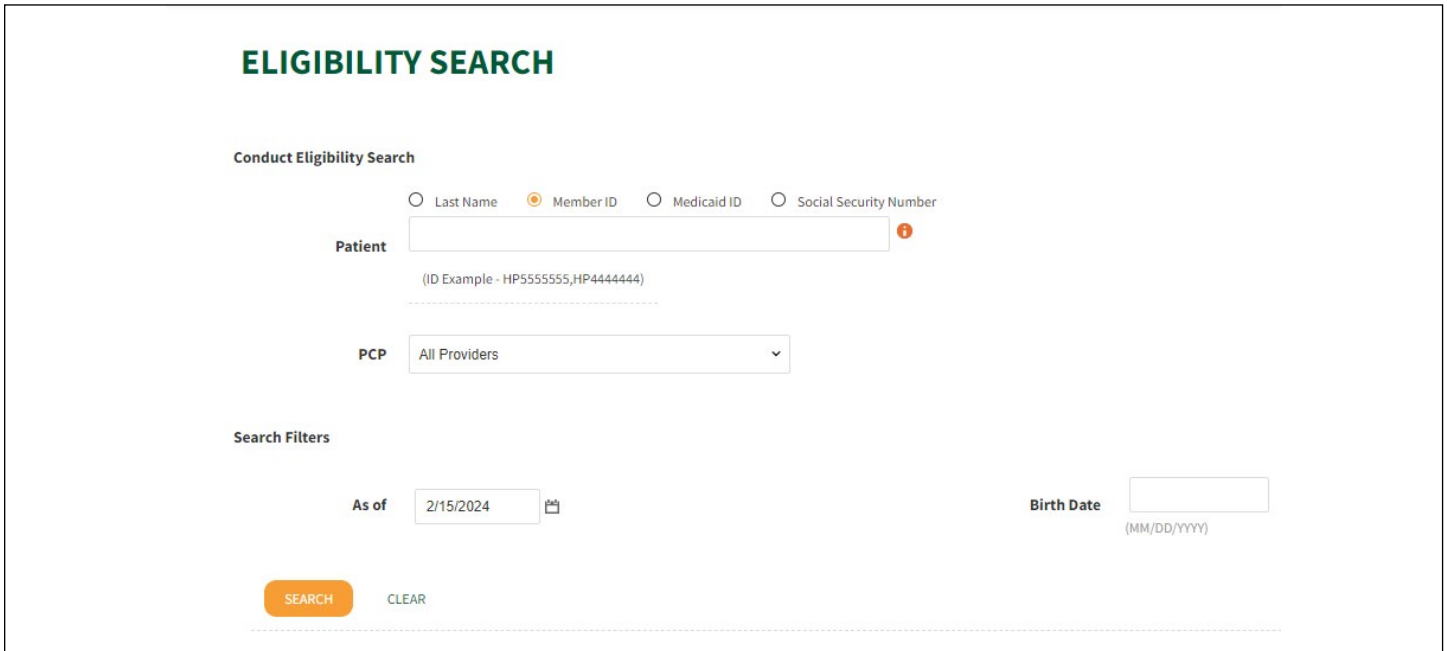


Users can search by (1) Last Name and DOB, or by (2) Member ID and DOB. Click the dropdown arrow next to Last Name to search by Member ID.

Users can also verify eligibility by selecting **Eligibility** under the Office Management drop down.

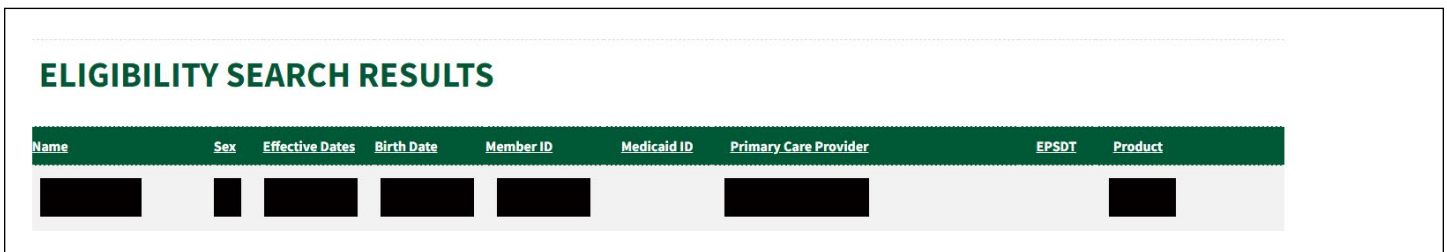


After selecting Eligibility, the **Eligibility Search** page will open.



The user can search by Last Name or Member ID.

Once the search is complete, the Member's name will appear in the **Eligibility Search Results** screen.



Name	Sex	Effective Dates	Birth Date	Member ID	Medicaid ID	Primary Care Provider	EPSDT	Product
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

On this screen, users can view the Member's:

- Name
- Gender
- Effective Date
- Date of Birth
- Member ID Number
- Primary Care Provider
- Product (line of business/insurance coverage)

By clicking on the Member's name, the results will expand. **This expanded view will show exactly how the Member's name must be entered on all claims.** It will also show the Member's demographic information, their eligibility history, and any other insurance coverage they may have.



Billing
For claims submission purposes submit the patient's name as follows:
First Name: [REDACTED]
Last Name: [REDACTED]

Benefits And Eligibility As Of 15 Feb 2024 [Download PDF](#)

Member Information

[REDACTED]

DOB: [REDACTED] Address: [REDACTED] PCP: [REDACTED]

Gender: [REDACTED]

Member ID: [REDACTED]

Phone: [REDACTED]

Benefit Plan Information

Group: [REDACTED] Status: [REDACTED]

Benefit Plan: [REDACTED] Start Date: [REDACTED]

End Date: [REDACTED]

Enrollment Origination Date: [REDACTED]

Dependents

NAME	BIRTH DATE	GENDER	MEMBER ID	RELATIONSHIP	PCP
[REDACTED]					

Other Insurance

No other insurance available.

[VIEW ELIGIBILITY HISTORY](#)

By clicking on the **Primary Care Provider's name**, the results will expand to show additional details for the selected Provider.

PROVIDER DETAIL AS OF 02/22/24 [Print](#)

Demographic Information

Name: [REDACTED] Phone: [REDACTED]

Address: [REDACTED] Provider NPI: [REDACTED] After Hours Phone: [REDACTED]

City, State Zip: [REDACTED] Office Hours: [REDACTED] Fax: [REDACTED]

Practice: [REDACTED] Accessibility: [REDACTED] Website: [REDACTED]

Email: [REDACTED]

Additional Information

Specialty: [REDACTED]

Languages: [REDACTED] Sex: [REDACTED]