Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen M. Corcoran, Director

Medicaid Clearance Letter

DATE: January 4, 2023

TO: Eligible Providers of Medicaid Services

FROM: Maureen M. Corcoran
Director, Ohio Department of Medicaid

SUBJECT: Amendments to Form Numbers ODM 06614 and ODM 6614i "Health Insurance Fact Request"

Summary

The Ohio Department of Medicaid (ODM) is seeking public comment on the following forms that are being proposed for amendment. These forms are being updated to reflect upcoming changes related to the next generation of Ohio Medicaid and how claims will be submitted. The following forms are being proposed for amendment:

- **ODM 06614 – Health Insurance Fact Request**

This form is used to update information related to private health insurance or Medicare. It requires certain elements to be reported such as provider information, recipient information, and insurance carrier information. This form is being updated to reflect the following proposed changes:

- The purpose of the form
- Updated terminology from "patient" to "recipient" for consistency
- Spelled out abbreviations
- Updated "Submit to" information

- **ODM 06653i – Instructions for Completing the Health Insurance Fact Request**

This form provides instructions on how to complete each section of the ODM form 06614. This form is informational and is intended to help the individual completing the ODM 06614 form. This form is being updated to reflect the following proposed changes:

- Reordered the provider information to align with how it is reflected on the 6614 form
- Updated terminology from “patient” to “recipient” for consistency
- Spelled out abbreviations
- Changed “mailing address” to “e-mail address”
- Language updated throughout for grammar
- Updated hyperlink to where the form can be found on the ODM website

Access to Rules and Related Materials

Stakeholders who want to receive notification when ODM original or final files a rule package may visit the Joint Committee on Agency Rules Review’s (JCARR) RuleWatch at www.rulewatchohio.gov where an account can be created to be notified of rule actions by the rule number or department.

Stakeholders can subscribe to receive notification when a clearance or business impact analysis (BIA) is posted by ODM for public comment on the Ohio Business Gateway here: https://governor.ohio.gov/priorities/common-sense-initiative/enotifications.

Additional Information

Questions pertaining to this letter may be directed to ODM in the following ways:

E-mail: Rules@medicaid.ohio.gov

Ohio Department of Medicaid

HEALTH INSURANCE FACT REQUEST

The ODM 06614 form is used to update information related to private health insurance or Medicare. Any other information cannot be processed by the third-party liability (TPL) & buy-in units.

For questions regarding updating the date of birth, gender, or other demographics – contact the county involved.

Please select which health insurance information to update. ☐ **Private Health Insurance** ☐ **Medicare**

Provider Information

Provider Number	Provider Name
Contact Person	Phone Number
Email Address	Fax Number

Recipient Information

Recipient(s) Name	Medicaid Billing Number		Recipient's Phone Number
Name of Insurance			
Address			
City	State	Zip Code	Insurance Carrier Phone Number
Policy Holder Name	Policy Number or Medicare Number		Policy Group Number
Policy Holder Social Security Number (SSN)		Policy Holder Phone Number	
If payment has been received from health insurance other than Medicaid or Medicare, please note first payment date.			
Health insurance termination date (attach documentation if available).			
Additional Comments			

Submit to: The Ohio Department of Medicaid
Cost Avoidance Unit
Coordination of Benefits Section
Fax number: (614) 728–0757
E-mail: TPLFAX@medicaid.ohio.gov

Ohio Department of Medicaid

INSTRUCTIONS FOR COMPLETING ODM 06614, HEALTH INSURANCE FACT REQUEST

Insurance Information Box - Check the box that applies, private health insurance, or Medicare.

Provider Information

Provider Number - Enter the ten-digit National Provider Identifier (NPI) or your seven-digit Medicaid provider number.
Provider Name - Enter the name of the provider to which Medicaid payment is to be made and who is assigned the ten-digit NPI or seven-digit Medicaid provider number.
Contact Person - Enter the name of the individual with whom contact is to be made if further information is needed.
Phone Number - Enter the telephone number including area code and extension, if applicable.
Email Address - Enter the email address for which correspondence relating to this form is to be sent.
Fax Number – Enter the fax number for which correspondence relating to this form is to be sent.

Recipient Information

Recipient(s) Name - Enter the name of the recipient to whom services were rendered.
Medicaid Billing Number - Enter the recipient's Medicaid twelve (12) digit billing number.
Recipient's Phone Number - Enter the telephone number including area code.
Name of Insurance - Enter the name of the health insurance or entity liable for payment other than Medicaid.
Address - Enter the complete mailing address of the health insurance or entity where claims are to be billed. Include the city, state, and zip code.
Insurance Carrier Phone Number - Enter the telephone number including area code and extension, if applicable, of the liable health insurance or entity for verification and/or claim processing.
Policy Holder Name - Enter the full name of individual(s) whom the liable health insurance or entity deems as holder of the policy. This will always be an individual not a company.
Policy Number or Medicare Number - Enter the Medicaid consumer's private health insurance policy or Medicare number. DO NOT ENTER THE MEDICAID BILLING NUMBER. For private health insurance, the number can also be the SSN of the policy holder.
Policy Group Number - Enter the group and/or employer number of the liable health insurance, if applicable.
Policyholder Social Security Number (SSN) - Enter the policyholder's SSN.
Policy Holder Phone Number - Enter the telephone number of the policy holder.
Date payment received - Enter the first date payment was received from Medicare or a source other than Medicaid.
Health Insurance Termination Date - Enter the actual date the policy was terminated. Supply supporting documentation, including the actual date of termination, of when the health insurance was terminated (e.g., EOB w/termination date or health insurance letter). For Medicare, indicate whether the termination date applies to Medicare Part A, Part B, or both.

Please note: *Failure to attach documentation to support the update of the health insurance may result in the Medicaid claims payment system not being updated.*

To get a copy of the *ODM 06614 HEALTH INSURANCE FACT REQUEST*, click on the following link: https://medicaid.ohio.gov/stakeholders-and-partners/legal-and-contracts/forms/forms.