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 No. - Enter the seven digit Medicaid provider number or your ten-digit National Provider Identifier.

Provider Name - Enter name of the provider to which Medicaid payment is to be made and who is assigned the Medicaid-seven-digit or ten-digit National-Provider-Identifier provider number.

Address - Enter the mailing address for which correspondence relating to this form is to be sent.

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.

Recipient Information

Patient(s) Name - Enter name of the patient to whom services were rendered.

Medicaid Billing No. - Enter patient's Medicaid twelve (12) digit billing number.

Patient's Phone Number - Enter telephone number including area code.

Name of Insurance - Enter name of the health insurance or entity liable for payment other than Medicaid.

Address - Enter complete mailing address of the health insurance or entity where claims are to be billed.

Insurance Carrier Phone Number - Enter telephone number including area code and extension, if applicable.

Policy Holder's 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 # or Medicare # - 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 No. - Enter group and/or employer number of the liable health insurance, if applicable.

Policyholder's Social Security Number (SSN) - Enter the policyholder's SSN.

Policy Holder's Phone Number - Enter telephone number including area code and extension, if applicable, of the liable health insurance or entity for verification and/or claim processing.

Name, Address, Phone Number of the Policy Holder's Employer - Enter policy holder's employment information, if this is a group policy.

Date payment received - Enter the first date payment was received from Medicare or a source other than Medicaid.

Verified 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 completed.

To get a copy of the ODM 06614, HEALTH INSURANCE FACT REQUEST, visit
http://medicaid.ohio.gov/RESOURCES/Publications/MedicaidForms.aspx