CHAPTER III

MEMBER ELIGIBILITY

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DETERMINING ELIGIBILITY

The Department of Medical Assistance Services (DMAS) administers Virginia's medical assistance programs: Medicaid (called FAMIS Plus for children), FAMIS for children under age 19 years, and FAMIS MOMS for pregnant women. FAMIS and FAMIS MOMS offer coverage similar to Medicaid but have higher income thresholds. Per state regulations, eligibility determinations for the medical assistance programs are made by the local departments of social services (LDSS) and by the Cover Virginia Central Processing Unit (CPU).

Inquiries from persons who wish to apply for medical assistance should be referred to the LDSS in the locality in which the applicant resides, to the Cover Virginia Call Center at 1-855-242-8282, or the Cover Virginia website at www.CoverVA.org. DMAS will not pay providers for services, supplies, or equipment until the applicant's eligibility has been determined. (See "Assistance to Patients Possibly Eligible for Benefits.") Once an applicant has been found eligible, coverage for Medicaid can be retroactive for up to three months before the month in which the application was filed. A member's eligibility must be reviewed when a change in the member's circumstances occurs, and all members are subject to an annual renewal (redetermination) of eligibility.

Groups Covered by Medical Assistance

Individuals who apply for Medicaid are evaluated under the covered group or groups they meet. Each covered group has a prescribed income limit, and some covered groups also have an asset or resource limit. Individuals may be eligible for full medical assistance coverage, including the payment of Medicare premiums for Medicaid members with Medicare, if they fall into one of the following covered groups and meet the nonfinancial and financial requirements for the group:

- Auxiliary Grants (AG) recipients
- Aged, blind or disabled (ABD) recipients of Supplemental Security Income (SSI) and certain former SSI recipients with "protected" status
- ABD individuals with income less than or equal to 80% of the Federal Poverty Level (FPL) who are age 65 or older and/or who are eligible for or enrolled in Medicare.
- Low-Income Families with Children (parents with a dependent child under age 18 years in the home)
- Pregnant women, and postpartum women through the end of the 12 month postpartum period (Medicaid, FAMIS MOMS)

- Newborns up to age one year born to mothers who were eligible for Medicaid or covered by FAMIS or FAMIS MOMS at the time of the birth

- Children in foster care or subsidized adoptions, and individuals under age 26 who were formerly in foster care until their discharge from foster care at age 18 or older.

- Children under age 19 years (FAMIS Plus, FAMIS)

- Adults between the ages of 19 and 64 who are not eligible for or enrolled in Medicare. These individuals are referred to as Modified Adjusted Gross Income (MAGI) Adults.

- Individuals under age 21 in institutional care

- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)—women and men who were certified through the Breast and Cervical Cancer Early Detection Program.

- Individuals who are in long-term care institutions or receiving services under a home and community-based care waiver, or who have elected hospice care.

The following individuals may be eligible for limited Medicaid coverage if they meet the nonfinancial and financial requirements for their covered group:

- Qualified Medicare Beneficiaries (QMBs) with income over 80% of the FPL but within 100% of the FPL. This group is eligible for Medicaid coverage of **Medicare premiums, deductibles, and coinsurance only**.

- Special Low-Income Medicare Beneficiaries (SLMB) with income less than 120% of the FPL. This group is eligible for Medicaid coverage of **Medicare Part B premiums only**.

- Qualified Individuals (QI) with income equal to or greater than 120% but less than 135% of the FPL. This group is eligible for Medicaid coverage of the **Medicare Part B premiums only**.

- Qualified Disabled and Working Individuals (QDWI) with income up to 200% of the FPL. This group is eligible for Medicaid payment of **Medicare Part A premiums only.**

- Plan First – any individual with income equal to or less than 200% of FPL.

This group is eligible for limited Medicaid coverage of family planning services only and not covered for full Medicaid benefits. If a member does not wish to be enrolled in Plan First, he or she should contact the local DSS to be disenrolled.

Medically Needy Covered Groups and Spenddown

Through a process known as "spenddown," Medicaid provides a limited period of full coverage for certain groups of "Medically Needy" individuals who meet all of the Medicaid eligibility requirements but have excess income for full benefit Medicaid. Individuals to which spenddown may apply include:

- ABD individuals
- Pregnant women and their newborn children
- Children under age 18
- Individuals under age 21 in institutional care, under supervision of the Department of Juvenile Justice, foster care, or subsidized adoptions
- Individuals in long-term care institutions and those receiving services under a home and community-based care waiver or who have elected hospice care.

To be eligible for Medicaid, the individual must have incurred medical expenses that at least equal the spenddown liability. If the individual's allowable medical expenses equal the spenddown liability amount before the end of a budget period (six-month period for non-institutionalized individuals or a one month period for institutionalized individuals), the applicant may receive a limited period of Medicaid coverage which will stop at the end of the budget period. The spenddown liability is the difference between the individual's income and the Medically Needy income limit for the individual's locality, multiplied by the number of months in the individual's spenddown period. Eligibility must be re-determined in order to establish eligibility in subsequent budget periods.

An individual placed on a spenddown does **not** have full Medicaid coverage until the spenddown is met, however they may be eligible for limited Medicaid coverage, Plan First, during the spenddown period. Medicaid cannot pay medical expenses incurred prior to the date the spenddown is met.

Emergency Medicaid Services for Aliens

To be eligible for full Medicaid or FAMIS benefits, an individual must be a resident of Virginia and a U.S. citizen or an alien qualified for full benefits. Included in this definition are lawfully residing immigrants who are pregnant or within the first 12 months postpartum, and lawfully residing immigrant children under the age of 19. In addition, the FAMIS Prenatal Coverage program offers prenatal coverage, through 60 days postpartum, for uninsured pregnant women up to 200% FPL who do not

meet immigration status criteria but are otherwise eligible for Medicaid or FAMIS MOMS.

Individuals who do not qualify for full Medicaid benefits due to their alien status may be eligible for Medicaid coverage of emergency services if they meet all other nonfinancial and financial eligibility requirements for full Medicaid coverage. Medicaid emergency services coverage for non-qualifying aliens is not available for the FAMIS and FAMIS MOMS programs.

LDSS staff determine eligibility for receipt of emergency Medicaid coverage based on regular eligibility criteria. The provider may refer the individual to the LDSS or Cover Virginia (see Chapter I for information on the covered services and the coverage criteria.)

If the member is found eligible they will be enrolled and a notice will be sent to them with their eligibility number. No ID card will be issued. DMAS will pay only for services coded as emergency care. The Emergency Medical Certification Form (#032-03-628) is no longer in use.

Medicaid Eligibility for Institutionalized Individuals

An institutionalized individual is defined as one who is receiving long-term services and supports (LTSS) as an inpatient in a medical institution or nursing facility or in the home or community setting. Home and community based services (HCBS) include waiver services such as personal care, adult day health care, respite care, and the Program for All Inclusive Care for the Elderly (PACE).

To be approved for Medicaid-covered LTSS, the individual must be institutionalized in a nursing or other medical facility or have been assessed and authorized for HCBS, and be eligible for Medicaid in a full-benefit covered group.

If an individual is not eligible for Medicaid in any other full-benefit covered group, the individual’s eligibility in one of the special income covered groups is determined. The policy for these groups allows a different method of determining income and resource eligibility, a higher income limit of 300% of the SSI payment for one person.

A married institutionalized individual's spouse at home is referred to as the community spouse. The community spouse is able to retain a specified amount of resources in order to continue to meet maintenance needs in the community. Some of the institutionalized spouse’s monthly income may also be allocated to the community spouse if certain criteria are met. At the time of application for Medicaid, the LDSS completes a resource assessment, producing a compilation of a couple's combined countable resources at the time one spouse became institutionalized and a calculation of a spousal share (the amount of shared resources that can be allocated to the community spouse). An institutionalized spouse with a community

spouse may also request a resource assessment without submitting a Medicaid application to assist with financial planning.

Most individuals receiving LTSS have an obligation toward the cost of their care, known as the patient pay. MAGI adults do not have a patient pay responsibility.

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY (FAMIS) PLAN

FAMIS Children

FAMIS is Virginia's Title XXI Children's Health Insurance Program (CHIP) and is a comprehensive health insurance program for children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit but no more than 200% of the FPL.

FAMIS provides twelve months of continuous coverage (beginning with the month the child was enrolled), unless:

- The family's gross monthly income goes over the income limit for the family size,
- The child moves out of Virginia,
- The child is found eligible for FAMIS Plus (children's Medicaid)
- The child turns age 19 during the 12 month enrollment period, or
- The family requests that the FAMIS coverage be stopped.

When children are initially enrolled in FAMIS they will have brief coverage in fee-for-service (FFS), with a Medicaid look-alike benefit package, before transitioning to a managed care organization (MCO). Once in managed care, FAMIS children are eligible for benefits similar to those covered for children under the State Plan for Medical Assistance, with some exceptions.

FAMIS MOMS

The FAMIS MOMS program covers uninsured pregnant individuals whose income is over the Medicaid income limit but no more than 200% of the FPL. This coverage extends through 12 months postpartum. FAMIS MOMS provides the same benefits to pregnant women as Medicaid, including dental services.

FAMIS Prenatal Coverage

Effective July 1, 2021, prenatal coverage is available through the FAMIS Prenatal Coverage program for uninsured pregnant individuals who meet all other eligibility criteria for Medicaid and FAMIS MOMS but do not meet immigration status rules. FAMIS Prenatal Coverage is available through the end of the calendar month in which the 60th postpartum day falls.

MEMBER ELIGIBILITY CARD

A blue and white plastic eligibility card is issued to members to present to participating providers. Plan First members receive a green and white identification card. **The provider is obligated to determine that the person to whom care or service is being rendered is the same individual listed on the eligibility card.** The provider has the responsibility to request such identification as he or she deems necessary. Presentation of a plastic ID card is not proof of coverage nor guarantee of payment. A sample of an eligibility card is included under “Exhibits” at the end of this chapter.

Eligibility must be confirmed each time service is rendered. Verification can occur through a verification vendor, the voice response system or the web-based verification system. LDSS do not provide verification of eligibility to providers.

Some individuals have coverage under a Virginia Medicaid/FAMIS contracted managed care organization (MCO) and should not receive services outside their network without a referral and authorization from the MCO. These members will have an MCO card in addition to the Medicaid/FAMIS card. The verification response will advise if the member has restrictions such as a contracted MCO enrollment, or a primary payer.

The provider must determine if the service is within the dates of eligibility. These dates must be checked prior to rendering any service. Benefits are available only for services performed during the indicated period of eligibility; Medicaid/FAMIS will not pay for care or services rendered before the beginning date or after the end date of eligibility.

Bank Identifier

The top six numbers on the plastic card represent the Bank Identifier Number (BIN), which is required for pharmacy benefit cards under the National Council of Prescription Drug Programs (NCPDP).

Name of Eligible Person

An eligibility card is issued to each person eligible for full Medicaid/FAMIS benefits and QMBs. Members enrolled in Plan First receive a green and white identification card. Check the name against another proof of identification if there is any question that the card does not belong to the member. Cards with “Do Not Use” or other non-names should not be accepted.

Member's Eligibility Number

The **member's** complete eligibility number is embossed on the front of the eligibility card. Eligibility numbers are distinct and permanent. When a member relocates or

moves into another case, or has a break in eligibility, he keeps the same number and the same card. When members are enrolled in Plan First, they will receive a green and white identification card. This number serves as a "key" in verifying current eligibility status.

All 12 digits must be entered on Medicaid forms for billing purposes.

Date of Birth

The date of birth indicates the member's age and identifies eligibility for those services with age restrictions, such as dental care for members under age 21 and pregnant women. The date of birth should be checked prior to rendering any services. The provider should verify the age of the member. If the provider has a question as to the age of the member, means of identification other than the Medicaid/FAMIS card should be examined.

Sex

The member's gender is indicated on the card.

Card #

The sequential number of the member's card is given. If a card is lost or stolen and another is issued, the prior card will be de-activated and will not confirm eligibility using the magnetic "swipe" mechanism.

Cardholder's Signature (signature line on back)

The signature line provides another element of verification to confirm identity.

VERIFICATION OF MEMBER ELIGIBILITY

It is the obligation of the provider of care to determine the identity of the person named on the eligibility card and the current eligibility status, to include program type or MCO enrollment. It is in the best interest of the provider to review the card each time services are rendered. Possession of a card does not mean the holder is currently eligible for benefits. **The member does not relinquish the card when coverage is cancelled.** Replacement cards must be requested.

Program/Benefit Package Information

Members' benefits vary depending upon the program in which they are enrolled. The eligibility verification will provide information on which program the member is participating in. Examples of these programs include Medallion 3.0, Medicaid fee-for-services, FAMIS MCO, CCC Plus, FAMIS fee-for-service and Medicare premium payment.

Limited Benefit Programs for Which Members Receive Eligibility Cards

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid Programs to expand the coverage of services to QMBs. There are two levels of coverage for QMBs, based on financial eligibility.

QMB Coverage Only—Members in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit, less the member's copayment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY--QMB." The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage—Members in this group are dually-eligible for full Medicaid coverage and Medicare. They are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. This group's Medicaid verification provides the message, "QUALIFIED MEDICARE BENEFICIARY--QMB EXTENDED." These members are responsible for copays for pharmacy services, health department clinic visits, and vision services.

SLMBs and QIs do not receive member eligibility cards because they are not eligible for the payment of medical services rendered.

Plan First—Men and women enrolled in Plan First can receive limited Medicaid covered family planning services only, and they receive a green and white plastic Plan First identification card. This group's Medicaid verification provides the message, "PLAN FIRST - FAMILY PLANNING SERVICES ONLY." See the Plan First Manual for more information.

All Others—Members without ANY of these messages at time of verification will be eligible for those covered services listed in Chapter I of this manual.

Special Indicator Code (formerly Copayment Code – Copayments are no longer charged for Medicaid and FAMIS eligible members)

The Special Indicator Code indicates eligibility for certain additional services. These codes are:

Code	Message
A	Under 21.
B	Individuals Receiving Long-Term Care Services, Home or Community-Based Waiver Services, or Hospice Care

C All Other Members

Insurance Information

The “Insurance Information” in the verification response indicates any type of insurance coverage the member has in addition to Medicaid. This information includes specific insurance companies, dates of coverage, policy numbers, and a code that specifies the particular type of coverage of the policy. These items are:

Carrier Code	A three-digit code indicating the name of the insurance carrier, e.g. 001 for Medicare (See Insurance Company Code List for these code numbers in “EXHIBITS” at the end of this chapter.) If the carrier code is 003 (not listed), call the member’s local eligibility worker for assistance in obtaining the name of the insurance carrier.
Begin Date	The first date on which this insurance policy was effective
Type Code	An alpha character describing the type of coverage provided by the policy, such as a "D" for dental coverage. (See the Type of Coverage Code List under “EXHIBITS” at the end of this chapter for a list of these codes.)
Policy Number/ Medicare Code	The specific policy or Medicare number for the insurance identified by the Carrier Code

Only insurance information for active policies during the period for which eligibility is requested is provided at verification. If the member reports insurance information different from what is on the card, refer the member to his or her LDSS eligibility worker to correct the data so bills will be processed correctly.

Under the assignment of benefits regulations, DMAS can act on behalf of the member (subscriber) and recover third-party payment from the primary carrier. Workers' Compensation and other liability insurances (e.g., automobile liability insurance or home accident insurance) **are always considered as primary carriers** for cases where coverage is applicable to the injury being treated. Because the member's eligibility card cannot indicate this coverage, it is necessary that cause-of-injury information be obtained from the member.

Primary Care Providers (PCPs) for the Client Medical Management Program

A primary care designation or restriction is imposed by the Member Monitoring Unit of DMAS as a result of high utilization of services by the member causing unnecessary or duplicate services. Eligibility verification will list the names of designated primary care providers (physician and/or pharmacy). The designated

providers must agree to the relationship prior to the designation appearing on the member's card. Unless it is an emergency, do not provide services without contacting the primary care provider first for authorization.

MANAGED CARE PROGRAMS

Most Medicaid members are enrolled in one of the Department's managed care programs (Medallion 4.0, CCC Plus, PACE). Each program has specific eligibility requirements and health plan assignment criteria for its members. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact and/or eligibility and assignment information for managed care plans can be found on the DMAS website for each program as follows:

- Medallion 4.0:
  http://www.dmas.virginia.gov/#/med4
- Commonwealth Coordinated Care Plus (CCC Plus):
  http://www.dmas.virginia.gov/#/cccplus
- Program of All-Inclusive Care for the Elderly (PACE)
  http://www.dmas.virginia.gov/#/longtermprograms

MEMBER WITHOUT AN ELIGIBILITY CARD

A member who seeks services should be considered responsible for all charges incurred unless eligibility is verified. The provider can verify eligibility without the card using two other identification keys, including name, Social Security Number, and date of birth. These can be used to access the MediCall automated System, the verification vendors, and the web verification system (ARS). See Chapter I for further information about verification methods. LDSS do not provide verification of eligibility to providers.

ASSISTANCE TO PATIENTS POSSIBLY ELIGIBLE FOR BENEFITS

If a patient is unable to pay for services rendered, the provider may refer the patient or the patient's authorized representative to the LDSS in the locality in which the applicant resides or to the Cover Virginia Call Center at 1-855-242-8282 for an application for health care coverage. The LDSS or Cover Virginia will notify the patient of eligibility or ineligibility. Medicaid assumes no financial responsibility for services rendered prior to the effective date of a member's eligibility. The effective date of Medicaid eligibility may be retroactive up to three months prior to the month in which the application was filed, if the patient was eligible during the retroactive period. Once a patient is found eligible, providers may bill Medicaid for covered

services, and upon receipt of payment from Medicaid, must reimburse the patient for the out-of-pocket expenses; Medicaid does not reimburse members for out-of-pocket expenses.

MEDICAID APPLICATIONS--AUTHORIZED REPRESENTATIVE POLICY

Medicaid eligibility requirements require an applicant or someone conducting business on his or her behalf to verify citizenship or alien status, declare all income and assets, and make assignment of insurance and medical support benefits. In order to accurately determine eligibility, LDSS must ensure that an individual who files an application or someone conducting business on behalf of the applicant has full knowledge of the applicant's situation and can provide correct information.

A Medicaid applicant must sign the application form unless the application is filed and signed by the applicant's legal guardian or conservator, attorney-in-fact, or other person who is authorized to apply on the applicant's behalf. If the applicant is unable to sign his or her name but can make a mark, the mark must be designated "his/her mark" and witnessed by one person.

A child under age 18 cannot legally sign a Medicaid application for himself or herself unless he or she is legally emancipated from his or her parents. If a child is not legally emancipated, his or her parent or legal guardian**,** an authorized representative designated by the parent or legal guardian, or a caretaker relative with whom the child lives must sign the application. Exception: A minor child under 18 years of age may apply for Medicaid on behalf of his or her own child.

A legally competent individual age 18 or older may authorize anyone age 18 or older to file a Medicaid application on his or her behalf provided that the authorization is in writing, identifies the individual or organization authorized to conduct business on his or her behalf, and is signed by the individual giving the authorization.

When an individual has been determined by a court to be legally incompetent or legally incapacitated, the individual's legally appointed guardian or conservator is the individual's authorized representative and can apply for Medicaid on the individual's behalf. If an individual does not have a legal guardian or authorized representative and is mentally unable to sign an application or designate a representative, the individual's spouse will be considered the authorized representative for Medicaid purposes. In situations where the individual is not married, is estranged from his or her spouse, or the spouse is unable to represent him or her, a relative of the individual who is willing to take responsibility for the individual's Medicaid business may be considered his or her authorized representative. Relatives who may be considered authorized representatives in this situation are, in the following order of preference: the individual's adult child; parent; adult sibling; adult niece or nephew; or adult aunt or uncle.

If it is determined that an individual cannot sign an application and does not have an attorney-in-fact or authorized representative, a Medicaid application may be filed by someone other than an authorized person provided the individual's inability to sign the Medicaid application is verified by a written statement from the individual's doctor. The statement must indicate that the individual is unable to sign and file a Medicaid application because of his or her diagnosis or condition. The LDSS will pend the application until it can be appropriately signed if it is determined that court action has been initiated to have a guardian or committee appointed for the individual or until an Adult Protective Services investigation concludes that guardianship proceedings will not be initiated. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of an individual who cannot designate an authorized representative.

An application may be filed on behalf of a deceased person by his or her guardian or conservator, attorney-in-fact, executor or administrator of his or her estate, surviving spouse, or a surviving family member, in the following order of preference: adult child, parent, adult sibling, adult niece or nephew, or adult aunt or uncle. The application must be filed within a three-month period subsequent to the month of the individual's death. Medicaid coverage can be effective no earlier than three months prior to the application month. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.

NON-MEDICAID PATIENT RELATIONSHIP

Medicaid-eligible members who elect to be treated as private patients or who decline to verify their Medicaid eligibility with providers will be treated as private pay patients by the provider and by DMAS. Providers are required to furnish supporting documentation whenever patients fall into either of these categories.

NEWBORN INFANT ELIGIBILITY

All newborn days, including claims for "well babies," must be submitted separately. "Well baby" days cannot be processed as part of the mother's per diem, and no information related to the newborn must appear on the mother's claim.

A newborn is automatically considered eligible for Medicaid or FAMIS through age 1 year if the newborn's mother was eligible for full coverage Medicaid or enrolled in FAMIS or FAMIS MOMS at the time she gave birth. A medical assistance application must be filed for any child whose mother was not eligible for Medicaid or enrolled in FAMIS/FAMIS MOMS at the time of the child's birth.

A streamlined way for hospitals to report the birth of the newborn is through the Medicaid MES/FAS Web Provider Portal www.virginiamedicaid.dmas.virginia.gov under the link "E-213". Any provider approved for access to the Portal may report the newborn's birth and receive the newborn's Member ID within 30 days via email.

The provider can verify newborn eligibility from the card using two other identification keys, including name, social security number, and the date of birth. These can be used to access MediCall, the verification vendors, and the web-based system, ARS.

See Chapter I for more information on eligibility verification.

MEDICAID ELIGIBILITY FOR HOSPICE SERVICES

To be eligible to elect hospice as a Medicaid benefit, an individual must be entitled to Medicaid benefits and be certified as terminally ill. "Terminally ill" is defined as having a medical prognosis that life expectancy is six months or less. If the individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected or revoked concurrently under both programs.

GUIDELINES ON INSTITUTIONAL STATUS

Federal regulations in 42 CFR 435.1009 prohibit federal financial participation in Medicaid services provided to two groups of individuals in institutions; these individuals are NOT eligible for Medicaid:

- individuals who are inmates of a public institution, and

- individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. A psychiatric residential treatment facility for children and adolescents is an IMD. An Intermediate Care Facility for the Intellectually Disabled (ICF-ID) is not an IMD.

<u>Inmates of a Public Institution</u>

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole. An individual is considered incarcerated until permanent release, bail, probation or parole.

An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid. The following are ineligible public institutions:

- public residential institutions with more than 16 beds
- residential facilities located on the grounds of, or adjacent to, a public institution with more than 16 beds.

Incarcerated Individuals

Incarcerated individuals (adults and juveniles) who are hospitalized can be eligible for Medicaid payment limited to services received during an inpatient hospitalization of 24 hours or longer, provided they meet all other Medicaid eligibility requirements.

Incarcerated individuals include:

- individuals under the authority of the Virginia Department of Corrections (DOC) or Virginia Department of Juvenile Justice (DJJ), and

- individuals held in regional and local jails, including those on work release.

Individuals are not eligible for full benefit Medicaid coverage while they are living in a correctional facility, regional or local jail or juvenile facility.

An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and can only be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

Once an individual is released from the correctional facility, he can be enrolled in full benefit Medicaid, provided he meets all Medicaid eligibility requirements.

Juveniles

In determining whether a juvenile (individual under age 21 years) is incarcerated, the federal Medicaid regulations distinguish between the nature of the detention,

pre- and post- disposition situations, and types of facilities.

a. Prior to Court Disposition

The following juveniles can be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

- juvenile who is in a detention center due to criminal activity
- juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution and can only be eligible for Medicaid payment limited to inpatient hospitalization. A list of secure detention facilities in Virginia is available on the Department of Juvenile Justice's web site: https://www.djj.virginia.gov/pages/residential/residential-services.htm.

If they go to a non-secure group home, they can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center.

A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to Medical Insurance Security (FAMIS) coverage.

c. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible for full-benefit Medicaid if he/she is a resident of an ineligible public residential facility. He can be eligible for Medicaid coverage limited to inpatient hospitalization if he is admitted to a medical facility for inpatient services.

<u>Who is Not an Inmate of a Public Institution</u>

An individual is NOT an inmate of a public institution if:

- the individual is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- the individual is in a public institution for a temporary period pending other arrangements appropriate to his needs. Individuals in public institutions for a

temporary period include:

- individuals admitted under a TDO
- individuals arrested then admitted to a medical facility
- inmates out on bail
- individuals on probation (including a juvenile on conditional probation or probation in a secure treatment center), parole, or conditional release
- juveniles in a detention center due to care, protection or in their best interest.

APPEALS OF ADVERSE ACTIONS

An appeal is a request for a review of an adverse decision taken by DMAS, a DMAS contractor, or another agency on behalf of DMAS. There are two types of appeals – a provider appeal, which may be filed by a provider or their authorized representative, and a client appeal, which may be filed by an individual or an authorized representative on the individual's behalf. The client appeals process is described below. The provider appeals process is described in Chapter II.

CLIENT APPEALS

Definitions

Administrative Dismissal – The dismissal of a client appeal on various grounds, such as lack of a signed authorized representative form, or the lack of a final adverse action from the Medicaid Managed Care Organization ("MCO"), other DMAS Contractor, or other agency acting on behalf of DMAS.

Adverse Action – means the denial or termination of enrollment or reduction in coverage, or the partial approval, denial, reduction, suspension, or termination of a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial

liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1. For non-members, defined as a request for review of an adverse action by DMAS, a DMAS Contractor, or another agency acting on behalf of DMAS.

2. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members enrolled in an MCO, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

3. For members receiving fee-for-service ("FFS") services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Internal Appeal – means a request to the MCO by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination. The internal appeal is the only level of appeal with the MCO and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Representative (or Authorized Representative) - means an individual who has been authorized to represent someone who received an adverse action. The authorized representative can be anyone such as a family member, friend, neighbor, provider, etc. However, the authorization for someone to serve as a representative for an individual 18 years of age or older <u>must be in writing and submitted to the DMAS Appeals Division to process the appeal</u>. This includes authorization for a provider to represent a member when the services at issue have not been rendered. Written authorization can include a power of attorney, proof of guardianship, or other legal documents establishing the representation. DMAS also has an authorized representative form available on its website at: https://www.dmas.virginia.gov/appeals.

State Fair Hearing – means the Department's *de novo* evidentiary hearing process for member appeals. Any adverse action by DMAS, a DMAS Contractor, or other agency acting on behalf of DMAS or internal appeal decision rendered by the MCO

may be appealed by the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

There are three types of client appeals, each of which is described below. The first two types, MCO and FFS, involve individuals who are enrolled in Medicaid or a Medicaid program and receiving services either through an MCO or through fee-for-service. The third type, non-member, involves individuals who are seeking to become enrolled in Medicaid or a Medicaid program.

Member Appeals (MCO)

A member, an attorney, a provider authorized to represent a member, or another authorized representative on behalf of the member have the right to appeal adverse benefit determinations to the Department. However, the MCO's internal appeal process must be exhausted, or deemed exhausted (due to the failure of the MCO to adhere to the notice and timing requirements), prior to a member filing an appeal with the DMAS Appeals Division.

Any member, member's attorney, or member's authorized representative wishing to appeal an adverse benefit determination must first file an internal appeal with the MCO **within 60 calendar days** from the date on the notice of adverse benefit determination. The internal appeal request may be submitted orally or in writing. For individuals with special needs or who do not understand English, the appeal rights must be provided in such a manner as to make it understandable by the individual.

A member may request continuation of services during the MCO's internal appeal and DMAS' State fair hearing. If an appeal is filed before the effective date of the action or within 10 days of the date the notice of adverse benefit determination was mailed, services may continue during the appeal process. If the final resolution of the appeal upholds the MCO's action and services to the member were continued while the internal appeal or State fair hearing was pending, the MCO may recover the cost of the continuation of services from the member.

Member appeals to DMAS are conducted in accordance with 42 C.F.R. § 431 Subpart E and the Department's Client Appeals regulations at Virginia Administrative Code 12 VAC 30-110-10 through 12 VAC 30-110-370.

If a member is dissatisfied with the MCO's internal appeal decision, the member or member's authorized representative may appeal to DMAS. Standard appeals of the MCO's internal appeal decision may be requested orally or in writing to DMAS. Expedited appeals of the MCO's internal appeal decision may be filed by telephone or in writing. The appeal may be filed at

any time after the MCO's appeal process is exhausted and extending through **120 days after receipt** of the MCO's appeal decision. Appeal requests may be sent to the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out a client appeal request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Client Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the client appeal. The request can be submitted by:
  - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
  - Email to appeals@dmas.virginia.gov; or
  - Fax to (804) 452-5454

- By phone at (804) 371-8488 or in-person at the Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.

The Department's State fair hearing decision may be appealed to the appropriate circuit court by the member in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. and the Rules of Court.

Member Appeals (FFS)

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code atf 12 VAC 30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Adverse actions may be appealed by the Medicaid member or by an attorney, by a provider authorized to represent the member, or other authorized representative on behalf of the member. Adverse actions include terminations of enrollment, or partial approvals, denials, reductions, suspensions, and terminations of service. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the adverse action is upheld by the hearing officer, the member will be expected to repay DMAS or the DMAS Contractor for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The DMAS contractor will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, DMAS or the DMAS contractor may not terminate or

reduce services until a decision is rendered by the hearing officer.

Appeals may be requested orally or in writing by the member, the member's attorney, or the member's authorized representative. Appeals filed orally or electronically must be received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be postmarked within 30 days of receipt of the notice of adverse action. Forms are available on the internet at https://www.dmas.virginia.gov/appeals or, or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request. Appeal requests may be sent to the DMAS Appeals Division through one of the following methods:

- Through AIMS at https://www.dmas.virginia.gov/appeals/. From there you can fill out a client appeal request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Client Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the client appeal. The request can be submitted by:
    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
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- By phone at (804) 371-8488 or in-person at the Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.

The Department's state fair hearing decision may be appealed to the appropriate Circuit Court by the member in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. and the Rules of Court.

NON-MEMBER APPEALS

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12 VAC 30-110-10 through 370, require that written notification be provided to individuals when DMAS, its contractors, or another agency on behalf of DMAS, takes an action that affects the non-member. Adverse actions may be appealed by the non-member, an attorney, a provider authorized to represent the member, or other authorized representative on behalf of the member. Adverse actions include denials of enrollment in the Medicaid program or denial of services that would result in enrollment in a Medicaid program. Also, failure to act within required timeframes may be

appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

Appeals may be requested orally or in writing by the member, the member's attorney, or the member's authorized representative. Appeals filed orally or electronically must be received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be postmarked within 30 days of receipt of the notice of adverse action. Forms are available on the internet at https://www.dmas.virginia.gov/appeals or by calling (804) 371-8488. A copy of the notice or letter about the action should be included with the appeal request. Appeal requests may be sent to the DMAS Appeals Division through one of the following methods:

- Through AIMS at https://www.dmas.virginia.gov/appeals/. From there you can fill out a client appeal request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Client Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the client appeal. The request can be submitted by:
  - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
  - Email to appeals@dmas.virginia.gov; or
  - Fax to (804) 452-5454

- By phone at (804) 371-8488 or in-person at the Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.

The Department's State fair hearing decision may be appealed to the appropriate circuit court by the member in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. and the Rules of Court.

EXHIBITS

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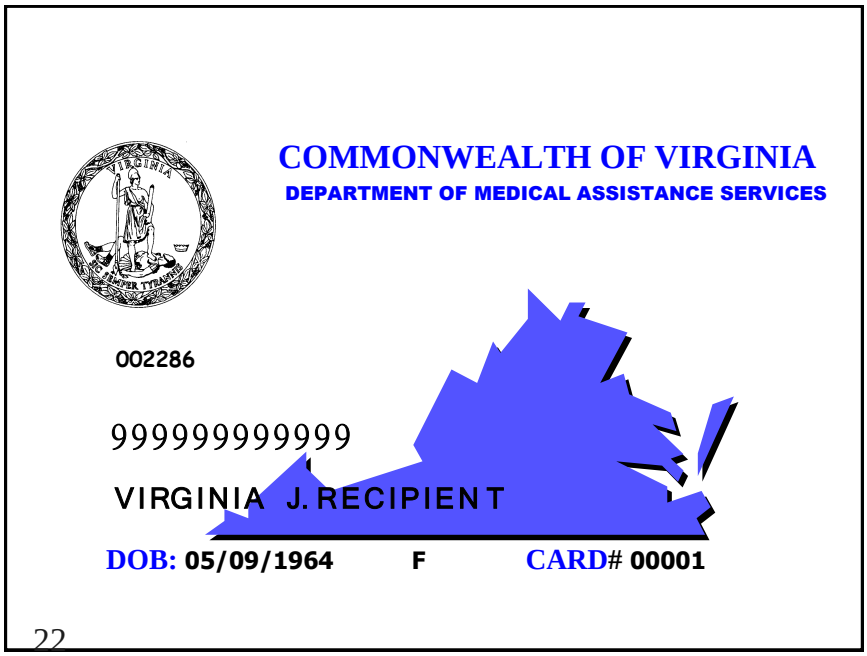
SAMPLE MEDICAID CARD



SAMPLE PLAN FIRST CARD

Department of Medical Assistance Services

MEDICAID/FAMIS NEWBORN ELIGIBILITY NOTIFICATION

This document is the official notification of the child's birth for Medicaid or FAMIS enrollment. For children born to a Medicaid/FAMIS/FAMIS MOMS eligible mother with full coverage, the Medicaid/FAMIS eligibility for the newborn begins on the date of birth.

ALL QUESTIONS MUST BE ANSWERED IN ORDER TO BE PROCESSED (Please Type or Print Clearly)

Mother's Name _____ Last _____ First _____ M.I.

Mother's SSN ___ - ___ - _____ **Mother's Date of Birth** ___ / ___ / _____ MM/DD/YY

Mother's Address _____ Street

_____ City _____ State _____ Zip

Mother's Medicaid/FAMIS/FAMIS MOMS ID Number (12 digits) ___ - ___ - ___

Mother's Telephone Number *(if known)* (___) ___ - ___

Full Name of Newborn(s)			Birth Date	Sex	Race
Last	First	MI	MM/DD/YY		
Last	First	MI	MM/DD/YY		
Last	First	MI	MM/DD/YY		

Submitted by _____ Name and Title **Telephone #** (_____) ___ - _____

Provider Name _____ Provider NPI _____

Provider Address _____ City State Zip

To access the Newborn E-213 link via DMAS provider web portal click https://www.virginiamedicaid.dmas.virginia.gov/wps/portal

To manually process, please fax or mail this form immediately to the Local DSS office for the Mother's case. Current listing of local DSS Agencies click www.dss.virginia.gov/localagency

DSS Use Only

Date Received ___ / ___ / ___ MM/DD/YY

Date Processed ___ / ___ / ___ MM/DD/YY

Note: Medicaid/FAMIS newborns must be linked to their mother's case when enrolled in MMIS.

INSURANCE COMPANY CODES

CARRIER CODE	CARRIER NAME
00001	MEDICARE
00002	ABSENT PARENT
00003	NOT LISTED
00004	AMERICAN COMM MUT LIFE INS CO
00005	ACADEMY LIFE INS CO
00006	AETNA US HEALTHCARE
00007	ALLSTATE INSURANCE CO
00008	AMERICAN DEFENDER LIFE INS CO
00009	AMERICAN FIDELITY ASSUR CO
00010	AMERICAN HERITAGE LIFE INS CO
00011	AMERICAN MUT LIABILITY INS CO
00012	AMERICAN RESERVE LIFE INS CO
00013	APPALACHIAN LIFE INS CO
00014	WILSET ASOCIATES INS
00015	WALMART ASSOC HLTH PLAN
00016	AMERICAN INCOME LIFE INS CO
00017	AMERICAN SENIOR CITIZENS
00018	AMERICAN CANCER
00019	AMERICAN INTEGRITY INS CO
00020	BANKERS FIDELITY LIFE INS CO
00021	BANKERS LIFE AND CASUA INS CO
00022	BANKERS LIFE INS CO OF NE
00023	BENEFICIAL NATIONAL
00024	BLUE RIDGE INSURANCE CO
00025	BUILDERS LIFE
00026	AMERICAN FAMILY LIFE ASSUR CO
00027	ATLANTIC LIFE INSURANCE CO
00028	AMERICAN MOTORISTS INS CO
00029	BENEFICAL MULTIPLE INS
00030	TRIGON BC/BS OF VA
00031	BLUE CROSS BLUE SHIELD SW VA
00032	BC/BS OF THE NAT'L CAP'TL AREA
00033	BLUE CROSS BLUE SHIELD MD
00034	ANTHEM BC/BS OF CHATTANOOGA TN
00035	BLUE CROSS BLUE SHIELD OF KY
00036	OTHER BC BS
00037	COMMONWEALTH LIFE INS CO OF KY
00038	CONSTITUTION LIFE INS CO
00039	COLUMBIA MUTUAL
00040	CHAMPUS
00041	CHAMPVA
00042	CHARTER SECURITY
00043	CHESAPEAKE LIFE INS CO
00044	THE CITADEL LIFE INS CO
00045	CITIZENS HOME
00046	COASTAL STATES LIFE INS CO
00047	COLONIAL LIFE ACCIDENT INS CO
00048	COLONIAL PENN INSURANCE CO
00049	COMBINED INS CO OF AMERICA

00050	CIGNA
00051	CONTINENTAL CASUALTY COMPANY
00052	CENTRL ST HLTH LIF INS OMAHA
00053	DEER
00054	FOUNDERS LIFE ASSURANCE CO
00055	KLAIS & COMPANY
00056	BENEFIT ADMIN OF AMERICA INC
00057	DURHAM LIFE INSURANCE CO
00058	GROUP HEALTH ASSOCIATION INC
00059	GUARANTEE TRUST LIFE INS CO
00060	EASTERN INSURANCE COMPANY
00061	EMMCO INSURANCE COMPANY
00062	EMPLOYERS LIFE INS CO WAUSAU
00063	EQUITABLE LIFE ASSURANCE
00064	EQUITY NATIONAL LIFE INS CO
00065	DARDEN RESTAURANTS
00066	GROUP HEALTH ASSOCIATION INC
00067	GUARDIAN LIFE INS CO OF AMER
00068	HEALTH BENEFIT ADMINISTRATORS
00069	AETNA INS CO FORT WAYNE
00070	FEDERAL HOME LIFE INS CO
00071	NAT'L CLAIM ADMIN SERV (NCAS)
00072	FEDERATED LIFE INS CO
00073	FIDELITY BANKERS LIFE INS CO
00074	FIREMANS FUND INS CO
00075	METRO MACHINE CORP
00076	HUNT TAYLOR
00077	FIRST VIRGINIA LIFE INS CO
00078	THE FRANKLIN LIFE INS CO
00079	IDEAL MUTUAL
00080	ITT LIFE INSURANCE CO
00081	INA BENFIT SER
00082	GEN FIDELITY
00083	GLOBE LIFE INSURANCE COMPANY
00084	GEOTWN COM HTH PLAN
00085	GOV EMP LIFE INS
00086	GULF LIFE INSURANCE CO
00087	BEVERLY ENTERPRISES
00088	INDEPENDENT LIFE ACCID INS CO
00089	THE LINCOLN NATL LIFE INS CO
00090	HARTFORD LIFE INSURANCE CO
00091	HERALD LIFE INSURANCE CO
00092	HOME BENEFICIAL LIFE INS CO
00093	HOME LIFE GROUP BENE SERV INC
00094	PEOPLE SECURITY INSURANCE CO
00095	LABORERS DIST COU VA HLTH WELF
00096	LIFE INVESTORS INS CO OF AMER
00097	MEDICO LIFE INSURANCE CO
00098	MONTGOMERY WARD LIFE INS CO
00099	INDEPENDENCE
00100	INTEGON LIFE INSURANCE CORP
00101	INTEGRITY NATL LIFE INS CO
00102	INTER STATE ASSURANCE COMPANY
00103	INVESTORS
00104	NATL ASSOC GOVER EMPLOY
00105	NATL SENIOR CITIZENS GROUP
00106	NATIONAL TRAVELERS LIFE CO

00107	JOHN HANCOCK MUTUAL LIF INS CO
00108	NATIONAL BENEFIT LIFE INS CO
00109	GREAT WEST LIFE ASSUR.CO-MD
00110	KENTUCKY CENTRAL LIFE INS CO
00111	KEY LIFE
00112	NATL ACCIDENT AND HLTH
00113	NATL LIFE AND ACCID INS CO
00114	NATIONAL CASUALTY CO
00115	LIBERTY LIFE INS CO
00116	LIBERTY NATIONAL LIFE INS CO
00117	LIFE AND CASUALTY INS CO TN
00118	LIFE INS CO OF GEORGIA
00119	LIFE INS CO OF NORTH AMERICA
00120	THE LIFE INSURANCE CO OF VA
00121	LINCOLN INCOME LIFE INS CO
00122	LONE STAR LIFE INSURANCE CO
00123	LUMBERMENS
00124	ORANGE STATE LIFE HLTH INS CO
00125	PEOPLES SECURITY LIFE INS CO
00126	PROTECTIVE LIFE INS CO
00127	THE PYRAMID LIFE INSURANCE CO
00128	MARYLAND LIFE
00129	MASSACHUSETTS GEN LIFE INS CO
00130	MASSACHUSETTS MUT LIFE INS CO
00131	MAYFLOWER NATIONAL LIFE INS CO
00132	MED INDEMNITY CO
00133	METROPOLITAN CASUALTY INS CO
00134	MIDLAND MUTUAL LIFE INS CO
00135	MID SOUTH INS CO
00136	MID STATES
00137	MIDWEST SECURITY INS CO
00138	MUTUAL OF OMAHA INS CO
00139	MUTUAL LIFE
00140	BENEFIT PLAN STRATEGIES
00141	NYHART (WYNN'S PRECISION)
00142	SOUTHEAST LIFE
00143	NATL AMER LIF INS CO OF PA
00144	BUSINESS ADMIN & CONSULTANTS
00145	NATIONAL HOME LIF ASSURANCE C
00146	INTERCARE BENEFIT SYSTEMS
00147	NATIONAL LIFE INSURANCE CO
00148	NATIONAL SAVINGS LIFE INS CO
00149	NATL UN FIRE INS PITTSBURG PA
00150	NATIONWIDE LIFE INSURANCE CO
00151	NEW YORK LIFE INSURANCE CO
00152	NORTH AMERICAN INS CO
00153	NORTHWESTERN NATL LIFE INS CO
00154	UFCW HLTH AND WELFARE FUND
00155	SOUTHWESTERN LIFE INS CO
00156	OCCIDENTAL
00157	OPTOMETRIC SERV CORP
00158	SENTRY LIFE INS CO
00159	STANDARD LIFE SEC INS CO OF NY
00160	PAUL REVERE LIFE INS CO THE
00161	PENN MUTUAL LIFE INS CO
00162	STONEBRIDGE INSURANCE COMPANY
00163	PENSION LIFE INS CO OF AMERICA

00164	PHYSICIANS LIFE IN CO
00165	JEFFERSON PILOT LIFE INS CO
00166	PIONEER LIFE INS CO OF IL
00167	PROVIDEN LIFE & ACCIDENT INS C
00168	PRUDENTIAL INS CO OF AMERICA
00169	CONFED ADMIN SERVICES INC
00170	C & O RAILROAD
00171	SENIOR AMER
00172	RELIANCE
00173	REPUBLIC AMERICAN LIFE INS CO
00174	NATIONAL FINANCIAL
00175	ROYAL GLOBE
00176	TRUST
00177	UNION LABOR LIFE INS CO
00178	UNION BANKERS INS CO
00179	UNITED EQUITABLE INS CO
00180	SAFECO
00181	SCHOLASTIC
00182	TRIGON ADMINISTRATORS - VA
00183	SHENANDOAH LIFE INS CO
00184	SOUTHERN AID LIFE INS CO INC
00185	SOUTHLAND LIFE INS CO
00186	SOUTHWEST GENERAL
00187	STATE FARM FIRE & CASUALTY CO
00188	SUN LIFE ASSURANCE CO OF CANAD
00189	ITPE-NMU
00190	NETWORK HEALTH PLAN CORP
00191	UNITED CHAMBER ASSUR PLN
00192	TRANS-GENERAL LIFE INS CO
00193	TRAVELERS
00194	TWENTIETH CENTURY LIFE INS CO
00195	AETNA-FMC CORPORATION
00196	UNION CENTRAL LIFE INS CO THE
00197	USAF DEPT OF DEFENSE
00198	UNITED FAMILY LIFE INS CO
00199	USAA LIFE INS CO
00200	UNION SECURITY LIFE INS CO
00201	UNITED AMERICAN INS CO
00202	UNITED FIRE INSURANCE COMPANY
00203	UNITED MIN WORK OF AMER HLTH
00204	UNIVERSAL LIFE INS CO
00205	CENTRAL RESERVE LIF OF N AMER
00206	UNITED INS CO OF AMERICAL
00207	NATIONAL FOUNDATION LIFE INS C
00208	WESTERN AND SOUTHERN LIFE INS
00209	ZEBA TRUST
00210	ALUMINUM WKRS
00211	AMALGAMATED CLOTHING & TEXTILE
00212	AMAL MEATCUTTERS
00213	AMERICAN FED OF GOVT EMP
00214	POSTAL WKRS UNION
00215	ASBESTOS WKRS
00216	BAKERY AND CONFECTIONERY BENE
00217	BRICKLAYERS UNION
00218	BRHD RAILWAY CLERKS
00219	CARPENTERS UNION
00220	COMM WKRS OF AMER

00221	CONST GEN LAB UNION
00222	INT ASSO MACHINSTS
00223	INT BRHD ELECT WKRS
00224	INT UN OP ENGINEERS
00225	IRON WORKERS TRUST FUND
00226	MILLWRIGHTS UNION
00227	NATIONAL ASSOC OF LTR CARRIERS
00228	MAIL HANDLERS BENEFIT PLAN
00229	PLAST & CEMENT
00230	PLUMBERS & STEAMFITTERS
00231	SHEET METAL WORKERS' LOCAL 100
00232	TEAMSTERS JOINT COUNCIL NO 83
00233	FOOD & COMM WKRS
00234	UNITED PAPERWKRS
00235	UNITED STEELWKRS
00236	WAREHOUSE EMP
00237	BENEFIT PLAN SERVICES
00238	GREAT AMERICAN INS CO
00239	BANKERS MULTIPLE LINE INS CO
00240	VA DENTAL PLAN
00241	VA FARM BUR MUT
00242	VA MUT BENEFIT
00243	VA SURETY CO
00244	VOLUNTEER ST
00245	EMERSON ELEC BENE PLAN T
00246	EASTERN MED SUPPLY POLIC
00247	HARDEN & CO
00248	WAUSAU INSURANCE COMPANY
00249	WESTERN NAT LIFE INS CO
00250	WORLD INS CO
00251	HEALTH CARE ADINISTRATORS INC
00252	CROWN LIFE INS CO
00253	KEYSTONE INS CO
00254	YOUTHGUARD
00255	UNITED BENEFIT LIFE INS CO
00256	VA HLTH AND ACCIDENT ASSOC
00257	GUARANTEE RESERVE LIF INS CO
00258	NATIONAL LIBERTY LIFE
00259	GEORGE WASHINGTON LIFE INS CO
00260	PENNSYLVANIA LIFE INS CO
00261	OLD AMERICAN INS CO
00262	MONUMENTAL LIFE INS CO
00263	CENTRAL VA UFCW
00264	NEWPORT NEWS SHIPYARD
00265	PHYSICIAN MUTUAL INS CO
00266	REINSURED LEX GROUP INS
00267	EMPLOYEE BENEFIT CLAIMS
00268	VETERANS LIFE INS CO
00269	WASHINGTON AREA CORP CAR
00270	WAYNE ADMIN GROUP INS
00271	NEW ENGLAND GEN LIFE INS CO
00272	FIRST CONTINENTAL LIFE & ACCID
00273	MOUNTAIN TRAIL INSURANCE
00274	NAT'L HOME HEALTH
00275	WILLIS CORROON ADMIN SERV
00276	VA INDEPENDENT COAL CORP
00277	UNITED OF OMAHA LIFE INS CO

00278	NAT'L LEAGUE OF POSTMAST
00279	BENEFITS PLAN SERVICES INC
00280	CONTRACT DRIVERS INS TRUST
00281	TRANS AMER ACCIDENTAL LF
00282	FOOD HEALTH CARE
00283	RICHMOND BENEFICAL LIFE
00284	UNION FIDELITY LIFE INS CO
00285	SOUTHERN LUMBER MANF SPE
00286	UNION PLAN ADMINSTRATIO
00287	WOODMEN OF THE WORLD LIF INS
00288	WASHINGTON NATIONAL INS CO
00289	NORTH CAROLINA MUT LIF INS CO
00290	SPERRY MARINE SYSTEM
00291	DEPARTMENT OF LABOR
00292	CIF SERVICE CENTER
00293	VIRGINIA PLAN
00294	THE MINISTERS & MISSIONARIES B
00295	KISER INSURANCE CO
00296	CENTRAL VA RETAIL CLERK
00297	COSTAL PLAIN INS
00298	N N INVESTORS LIFE INS
00299	STUDENT ACCIDENT PROTECT
00300	VA DENTAL SERVICE PLAN
00301	WEAVER ASSOCIATES
00302	HORSEMEN BEN & PROT ASSOC
00303	PACIFIC MUTUAL LIFE INS CO
00304	THE OHIO STATE LIFE INS CO
00305	DELTA DENTAL PLAN OF VA
00306	POSTMASTERS BENEFIT PLAN
00307	EQUICOR
00308	ESMARK
00309	OPTIMA HEALTH PLAN
00310	SMITHFIELD FOOD HEALTH PLAN
00311	J P KENNEDY INS CO
00312	HUMANA INSURANCE
00313	ALLIANCE HLTH BENE PLAN
00314	HRSA/ILA
00315	ROLLINS INS CO
00316	AARP
00317	TIME INSURANCE COMPANY
00318	COSTAL HEALTH CARE PLAN
00319	HMO PLUS
00320	HEALTH AMERICA
00321	QUAKER CITY
00322	MONUMENTAL GENERAL INS CO
00323	UNION LIFE/HOSP INDEMNIT
00324	UNION FEDERAL NATIONAL
00325	COLONIAL BENEFIT ADMINISTRATOR
00326	AETNA
00327	NORTHEAST DELTA INSURANCE
00328	H J WILLIAMS COMPANY INS
00329	BENEFICIAL STANDARD LFE INS CO
00330	FEDERAL LIFE INS CO
00331	BAYLY MARTIN & FAY INS
00332	HMO OF PENNSYLVANIA
00333	BOILERMAKER NAT HLTH & WEL FND
00334	ENGINEERS UNION 106

00335	U S FIDELITY & GUARANTY
00336	AVTEX FIBERS INC
00337	STOUFERS CONCOURSE HOTEL
00338	LOYAL AMERICAN LIFE INS CO
00339	PRUDENTIAL AUTO DEALER
00340	SECURITY TRST LFE INS CO OF GA
00341	STATE MUTUAL INS CO OF AMERICA
00342	NAT'L CAPITAL ADMIN SERVC
00343	KISER GEORGETOWN INS
00344	PRIVATE HEALTH CARE SYS
00345	SECARE 65
00346	TEACHERS PROTECTIVE MUT LFE IN
00347	CCEB TRUST
00348	SEA FARERS
00349	CNS WHOLESALE GROCERY
00350	WEYERHAEUSER GROUP INS
00351	MAIL HANDLERS BENEFIT PLAN
00352	CHOICE INS HEALTH PLAN
00353	MWH MEDICORP MEDICAL PLN
00354	GOVERNMNT EMPLOYEES HOSP ASSOC
00355	VULCAN LIFE INS CO
00356	JOHN ALDEN LIFE INS CO
00357	PROVIDERS ALLCARE ADMINISTRATO
00358	LIFE & HLTH INS CO OF AMERICA
00359	CENTRAL LIFE ASSURANCE CO
00360	IBEX BENEFITS
00361	GREAT WESTERN
00362	CONFEDERATION LIFE
00363	BLUE CROSS/BLUE SHIELD OF MASS
00364	AMERICAN REPUBLIC INS CO
00365	HLTH CARE PLAN ADMIN
00366	HORACE MANN INS CO
00367	GENERAL AMERICAN INS CO
00368	OXFORD LIFE INSURANCE CO
00369	GENERAL AMERICAN INS CO
00370	NORTH BROOK INSURANCE
00371	HERITAGE NAT'L HLTH PLAN
00372	GLOBAL INS MANAGEMENT
00373	FLORIDA ROCK INDUSTRIES
00374	VETERANS OF FOREIGN WARS
00375	HUDSON GROUP ADMINIS
00376	KAISER PERMANENTE
00377	HARVEST LIFE INS CO
00378	TENNESSEE COMPANY GROUP
00379	TRANSPORT LIFE INSURANCE CO
00380	CONTROL DATA SYSTEMS INC.
00381	GREAT WEST LIFE ASSURANCE CO
00382	HECHINGER
00383	HOME BLDS ASSOC OF VA HLTH BNF
00384	GREAT WEST LIFE ASSURANCE CO
00385	CHESTERFIELD RESORCE INC
00386	SECURITY TRST LFE INS OF GA
00387	HILTON NEVADA CORP GRP HLTH BN
00388	DAYSTORM LADD FURNITURE
00389	SENTARA HEALTH PLAN
00390	CAPITOL AMERICAN LIFE INS CO
00391	PRINCIPAL MUTUAL LIFE INS CO

00392	FIELDCREST MILLS
00393	HUDSON GROUP ADMINISTRATOR
00394	GOLDEN RULE LIFE INS CO
00395	CONSUMERS UNITED LIFE INS CO
00396	COMPREHENSIVE BENEFITS SERV CO
00397	DEAN COMPANY EMPLOYEE
00398	PLANNED ADMINISTRATOR INC.
00399	AWANA CLUBS INT'L GROUP INS
00400	DAN RIVER MILLS INC
00401	LINCOLN NATIONAL LIFE INS CO
00402	BOOKE AND COMPANY
00403	MEDICAL DOCTORS INDIV PRACTICE
00404	CORPORATE SYSTEMS ADMIN
00405	TRANSPORT LIFE INS COMPANY
00406	C AND A INSURANCE COMPANY
00407	FEDERAL EXPRESS CORP GRP HLTH
00408	ROSES INTERACTIVE MEDICAL SER
00409	CHARLES CO EMPLOYEE BENEFIT TR
00410	PROVIDERS ALLCARE ADM
00411	SETTLERS LIFE INS CO
00412	NORTHERN GROUP SERVICES INC
00413	AID ASSOCIATION FOR LUTHERANS
00414	OLD SURETY LIFE OF TEXAS
00415	PACIFIC FIDELITY LIFE INS CO
00416	LANE CO IN HLTH CARE PLAN
00417	REYNOLDS METALS INSURANCE
00418	C AND O EMPLOYEES HOSP ASSOC
00419	CAMPBELL TAGGART INC
00420	COBRA SERVICE
00421	BASSETT WALKER
00422	ATLANTA GROUP BENEFIT CENTER
00423	LONG - AIR DOX CO
00424	ALTA
00425	UNITED FURNITURE WORKERS INS
00426	ATLANTA LIFE INSURANCE CO
00427	GROUP HEALTH ADMINISTRATORS
00428	MEDICAL FACILITIES OF AMERICA
00429	CIGNA
00430	ADVANCED INSURANCE SERVICE
00431	ITT HARTFORD LIFE & ANNUITY
00432	HEALTH CLAIM SERVICES
00433	FRINGE BENEFIT REVIEW
00434	NGS AMERICAN
00435	JEFFERSON PILOT C/O AMPRO FISH
00436	CRUM & FOSTER INS COMPANIES
00437	T P A OF GEORGIA
00438	SECURITY LIFE INS CO OF AMER
00439	MCDONOUGH-CAPERTON BENEFIT SER
00440	PCS HEALTH SYSTEM CLAIMS
00441	LAWRENCE MUSGROVE ASSOC
00442	WASHINGTON POST - SELF INSURER
00443	OPTIMUM CHOICE INC
00444	BLUE CROSS BLUE SHIELD(EMPIRE)
00445	G H I
00446	BENEFIT PLAN ADMINISTRATORS
00447	B/C - B/S OF ILLINOIS
00448	JOHN DEERE LIFE INS COMPANY

00449	NRECA NAT'L ROYAL ELECTRIC COR
00450	H. L. DUKE & COMPANY
00451	AMERICAN NATIONAL INS CO
00452	THE MUTUAL GROUP
00453	ACORDIA LOCAL GOV'MNT BENEFITS
00454	AM FOREIGN SERV PROT ASSOC
00455	E B SERVICES INC
00456	SELF FUNDED PLANS INC
00457	PHYSICIANS ASSOC
00458	FLEETWOOD INDUSTRIES
00459	PAID PRESCRIPTION PROGRAM
00460	SOUTHERN HEALTH INSURANCE
00461	HEALTH PLUS
00462	B/C - B/S OF NORTH CAROLINA
00463	CAPITAL CARE BC BS
00464	NATIONAL HEALTH INS CO
00465	E D S ELECTRONIC DATA SYSTEM
00466	INSUREX BENEFITS
00467	BENEFIT CONSULTANT SERVICES
00468	MAMSOVA
00469	AETNA LIFE INS CO NC
00470	TOWER LIFE INSURANCE CO
00471	SERV BEN PLAN RETAIL PHARM PRO
00472	UNITED STATES LIFE INS CO
00473	NATIONAL BENEFIT PLANS
00474	CHESAPEAKE BAY FISHING CO
00475	JOHN HANCOCK INS CO
00476	GROUP HEALTH COOPERATIVE
00477	AMALGATED LIFE INS CO
00478	SAVERS LIFE INS CO
00479	METLIFE (METROPOLITAN)
00480	CIGNA HEALTHCARE
00481	ROSES INC
00482	BLUE CROSS/BLUE SHIELD-MI
00483	BLUE CROSS BLUE SHIELD OF WV
00484	BMA BUSINESS MEN'S ASSURANCE
00485	HEALTH STRATEGIES
00486	CORPORATE BENEFITS SERVICE INC
00487	HEALTHKEEPERS
00488	BLUE CROSS BLUE SHIELD OF AL
00489	BC/BS OF PA (INDEPENDENCE)
00491	AETNA LIFE INS CO INDIANA
00492	KANAWHA INSURANCE CO
00493	AMERICAN MEDICAL SECURITY
00494	AMER POSTAL WORKERS UNION PLAN
00495	TRAVELERS
00496	PRIORITY HLTH CARE-HLTHKEEPERS
00497	NATL ASSOC OF HOME BUILDERS
00498	EMPLOYERS HEALTH INS CO
00499	BORDEN INC
00500	PAN AMERICAN LIFE INS CO
00501	THE GUARDIAN
00502	NOBLE LOUNDES AND JOHNSON
00503	CONTINENTAL GENERAL INS CO
00504	SOUTHERN BENEFIT SERVICE
00505	AMER BANKERS LIFE ASSUR OF FL
00506	NATIONWIDE LIFE INS CO

00507	GUARANTEE MUTUAL LIFE INS CO
00508	PIECE GOOD SHOPS INC SELF INSU
00509	WASHINGTON WHOLESALERS INS CO
00510	STATE FUND WORKERS COMPENS INS
00511	ADMINISTRATIVE CONSULTANTS
00512	BLUE CROSS BLUE SHIELD OF FL
00513	GROUP BENEFITS SERVICES
00514	PHOENIX MUTUAL LIFE INS
00515	DUKE AND CO EMPLOYEE BEN MANAG
00516	THE PRINCIPAL FINANCIAL GROUP
00517	PLUMBERS PIPEFITTERS MED FUND
00518	EMPLOYEE BENEFIT MANAGEMENT CO
00519	CENTRAL BENE NATL LIFE INS CO
00520	FORTIS BENEFITS INS CO
00521	BLUE CROSS BLUE SHIELD OF MO
00522	ALICARE INC
00523	RURAL ELECTRIC GRP INS ADMINIS
00524	METROPOLITAN LIFE INS CO
00525	BLUE CROSS BLUE SHIELD OF TX
00526	CLAIMSWARE INC
00527	HEALTH RISK MANAGEMENT
00528	THE MEGA LIFE & HEALTH INS CO
00529	BC/BS OF MAINE
00530	TPA OF FORT WORTH
00531	ACORDIA NATIONAL
00532	BC/BS OF CENTRAL NEW YORK
00533	DIVERSIFIED GROUP ADMIN. INC.
00534	AFF TEAMS HLTH/WEL MD-LOCAL311
00535	PIEDMONT ADMINISTRATORS
00536	FIRST HEALTH - UTAH
00537	GLOBE LIFE & ACCIDENT INS. CO.
00538	COMMUNITY MUTUAL INS CO
00539	BLUE CROSS-BLUE SHIELD-HIGHMRK
00540	CIGNA
00541	THE GUARDIAN
00542	ALLIANCE ASSURANCE CO
00543	TRAVELERS-NEW YORK
00544	UNITED MEDICAL RESOURCES INC
00545	HEALTH SOURCE INS GROUP
00546	AMERICAN CONT LIFE INS CO
00547	TRAVELERS-DENTAL-NEW YORK
00548	HMO OF VIRGINIA
00549	A CONSULTING SERVICES
00550	AETNA HEALTH PLAN-OHIO
00551	FCE BENEFIT ADMINISTRATORS
00552	FIRST HLTH ADVANTAGE-PROVIDIAN
00553	PRO CLAIM ADMIN INC (PROCLAIM)
00554	CORESOURCE INC (NC)
00555	METRAHEALTH
00556	CORESOURCE INC
00557	DUKE BENEFITS SERVICES
00558	PHARMACY NETWORK NAT CORP
00559	BANKERS UNITED LIFE ASSURANCE
00560	SOUTHERN HEALTH SERVICES
00561	GRGE WASHINGTON UNIV HLTH PLAN
00562	METRO LIFE INS CO (DE)
00563	BA MULLICAN LUMBER/MANUF CO

00564	HOME LIFE GP BEN & SERV INC
00565	CONTINENTAL ASSURANCE CO
00566	AETNA LIFE INS CO - TX
00567	BC/BS OF WI
00568	NAT TELE COOP ASSOC/GRP HLTH
00569	AMPRO FISHERIES COMPANY
00570	EXPRESS SCRIPTS
00571	HARRINGTON BENEFIT SERVICES
00572	PARTNERS NAT HLTH PLANS NC
00573	GROUP INSURANCES SERVICES
00574	ASSOCIATED BENEFITS CORP OF TN
00575	FOUNTAINHEAD ADMIN INC
00576	SINGER FURNITURE - ROANOKE
00577	HUMANA HEALTH PLAN
00578	BLUE CROSS AND BLUE SHIELD TN
00579	CHUBB LIFEAMERICA INS. CO
00580	SPECTRUM ADMINISTRATORS
00581	GENERAL HEALTH BENEFITS
00582	BLUE CROSS AND BLUE SHIELD NJ
00583	HEALTHTRUST
00584	BLUE CROSS AND BLUE SHIELD MS
00585	AMINITRON
00586	TRAVELERS PLAN ADMIN OF TENN
00587	GALLAGHER BASSETT
00588	ALEXANDRIA HOSPITAL PLAN
00589	PROVIDENT LIEF AND ACCID
00590	HEALTHSOURCE PROVIDENT-MEDICAL
00591	NASI WELFARE FUND
00592	WILLSE & ASSOCIATES INC
00593	CLAIM MANAGEMENT SERVICE
00594	PENN WESTERN BENEFITS INC
00595	PHILADELPHIA AMERICAN LIFE INS
00596	JONBIL INC
00597	ELECTRO-MECHANICAL CORP
00598	COLUMBIA FOREST PRODUCTS
00599	FEDERAL BLACK LUNG ASSOC
00600	JEFFERSON PILOT LIFE INS CO TN
00601	GENERAL ELECTRIC MED BENEFITS
00602	E.B.C. MID-AMERICAL
00603	HELATH NETWORK AMERICA
00604	MENNONITE MUTUAL AID
00605	THE TRAVELERS-MANAGED CARE SYS
00606	LIFE INSURANCE CO OF N AMER
00607	MEDICAL CLAIMS MANAGEMENT CORP
00608	METRA HLTH/RAILROAD ACCOUNTS
00609	MAMSI
00610	CAREMARK PRESCRIPTION SERV DIV
00611	MID-ATLANTIC MED SERV
00612	NEW YORK LIFE/HEALTH PLUS
00613	WEIMAN UPHOLSTERY
00614	ACORDIA NATIONAL-BC/BS OF KY
00615	POWELL MOUNTAIN COAL CO INC
00616	NOBEL GROUP BENEFITS
00617	BLUE CROSS/BLUE SHIELD OF NJ
00618	U S HEALTHCARE
00619	MCKEE FOODS GROUP BENEFITS
00620	STATE FARM INSURANCE

00621	BLUE CROSS/BLUE SHIELD OF IOWA
00622	BASSETT FURNITURE
00623	BRENCO INC
00624	BLUE CROSS/BLUE SHIELD OF SC
00625	NEW RIVER INDUSTRIES INC
00626	BLUE CROSS/BLUE SHIELD KANSAS
00627	COST MANAGEMENT TECHNOLOGIES
00628	BLAIR MILL ADMINISTRATORS
00629	CENTRA HEALTH BENEFITS
00630	MAN-U SER CONTRACT TRUST FUND
00631	WILLIAM TALLEY SIGN CO
00632	B.P.S. INC
00633	CELTIC LIFE INS CO
00634	LADD MEDICAL CLAIMS DEPT
00635	SELF INSURED SERV CO
00636	SHOOSMITH BROTHERSINC HLTH PLN
00637	MANCHESTER GROUP HEALTH PLAN
00638	DOANE PRODUCTS CO GROUP BENE
00639	EDUCATORS MUTUAL LIFE
00640	CENTRAL CAROLINA WAREHOUSE GRP
00641	MANGE-MEDICAL-CLAIMSWARE
00642	ELECTRICAL WELFARE TRUST FUND
00643	PRUDENTIAL INSURANCE COMPANY
00644	MET LIFE DENTAL
00645	GREAT WEST LIFE & ANNUITY INS
00646	BASSETT EMPLOYEE BENEFITS
00647	ANTHEM LIFE
00648	CIGNA HEALTHCARE OF VA
00649	JOHN HANCOCK
00650	JOHN DEERE HLTH CARE
00651	HILSTON VALLEY MED CTR
00652	THE GUARDIAN
00653	SOTHERN HEALTH TPA
00654	NETWORK INSURANCE INC
00655	ROCCO BENEFITS
00656	MANPOWER
00657	LAB DIST CO HL & WEL TRST FD#2
00658	MASS MUTUAL UNICARE
00659	JONES HILL & MERCER EMPL BENE
00660	BLUE CROSS AND BLUE SHIELD
00661	AETNA LIFE INS CO-PENNSYLVANIA
00662	CARILION HEALTH PLANS
00663	AETNA LIFE INS CO-FLORIDA
00664	CIGNA-DELEWARE
00665	STARMARK
00666	MEDICARE PART B-RAILROAD
00667	AETNA HEALTH PLAN-OKLAHOMA
00668	FIRST HEALTH-MARYLAND
00669	GREAT WEST LFE ASSUR CO PITTSB
00670	CONTINENTAL LIFE AND ACCIDENT
00671	TYSON FOODS INC
00672	STRATEGIC RESOURCE COMPANY
00673	WASHINGTON GAS & LIGHT CO
00674	AETNA LIFE INS CO -MASS
00675	DENTAL HLTH ADMIN & CONSLT SR
00676	FAISON INSURANCE ASSOCIATES
00677	TEACHER'S STATE EMPLOYEES'

00678	HEALTH PLANS INC
00679	FEDERATED MUTUAL INS.
00680	ACORDIA BENEFITS OF THE SOUTH
00681	ADMINITRON INC.
00682	ACORDIA BENEFITS
00683	HEATAC INC.
00684	VIRGINIA SPRINKLERS
00685	MANAGED PRESCRIPTION SERVICES
00686	PULASKI FURNITURE CORPORATION
00687	PIEDMONT COMMUNITY HEALTH PLAN
00688	CONSUMER DENTAL CARE
00689	ALTA HEALTH STRATEGIES INC
00690	METRAHEATLH
00691	AETNA LIFE INS CO-TYLER TX
00692	EMPLOYESS PLAN INC
00693	FEDERAL EMP BENE-TRIGON BCBS
00694	DONOVAN BENEFIT SYSTEMS INC
00695	EXPRESS SCRIPTS INC
00696	NATIONAL PRESCRIPTION ADM-NPA
00697	KIRK VAN ORSDEL INC
00698	BLUE CROSS & BLUE SHIELD OHIO
00699	GOODYEAR GROUP INS.
00700	INDIANAPOLIS NEWPAPERS INC
00701	VIRGINIA HEALTH NETWORK
00702	EPOCH GROUP
00703	UNITED HEALTHCARE CORPORATION
00704	THE NEW ENGLAND CARE HLTH PLAN
00705	COLUMBIA HOSP CORP OF AMERICA
00706	PROVANTAGE
00707	MEDIPLUS
00708	FIRST ALLMERICA FINAN LIFE
00709	BC/BS OF CT
00710	CENTRAL UNITED INSURANCE CO
00711	AETNA LIFE INS CO - CALIF
00712	DONNKENNY APPAREL INC.
00713	ALLMERICA FINANCIAL
00714	SRX PHARMACY SPECIALISTS
00715	HEALTHSOURCE PROVIDENT
00716	BC/BS OF PA (CAPITAL)
00717	L & H ADMINISTRATORS
00718	GRAPHIC COMM & NAT'L H & W FND
00719	RELIASTAR(PRESTO PROD-#187119)
00720	METROPOLITAN LIFE INS CO-ILL
00721	QUALCHOICE OF NORTH CAROLINA
00722	AETNA HEALTH PLAN-MID-ATLANTIC
00723	WISCONSIN PHYS SERV/INSUR-TEC
00724	GATEWAY HEALTH ALLIANCE
00725	CORPORATE HEALTH ADMINISTRATOR
00726	AETNA LIFE INS CO - MICHIGAN
00727	PRUDENTIAL INS CO (ALBANY)
00728	TRIGON ADMINISTRATORS - NC
00729	AETNA LIFE INS CO - READING
00730	BC/BS OF PUERTO RICO
00731	AETNA LIFE INS CO - FRESNO CA
00732	STANDARD INSURANCE COMPANY
00733	YOUNG LIFE BENEFIT PLAN
00734	BLUE CROSS/BLUE SHIELD-CALIF

00735	BC/BS OF ARKANSAS
00736	AETNA INS CO.- KENTUCKY
00737	AETNA HEALTH PLAN - ILLINOIS
00738	BLUE CROSS/BLUE SHIELD
00739	ANTHEM BLUE CROSS/BLUE SHIELD
00740	PRUDENTIAL HEALTHCARE GROUP
00741	POSITIVE CARE ADMINISTRATORS
00742	TYSON FOODSINC-TEMPERANCEVILL
00743	EMPLOYEE BENEFIT SERVICES INC
00744	ALLIED ADMINISTRATORS
00745	PRINCIPAL HLTH CARE OF MID-ATL
00746	CENTRA
00747	THE DARBY CHOICE PROGRAM
00748	PRUDENTIAL HEALTHCARE
00749	PENINSULA HEALTHCARE
00750	INTERACTIVE MEDICAL SYSTEMS
00751	VALUE BEHAVIORAL HEALTH
00752	HEWITT COLEMAN AND ASSOCIATES
00753	USA HEALTH NETWORK
00754	ONE HEALTH PLAN
00755	MEDIPLAN
00756	CNA INSURANCE CO
00757	SOUTHAMPTON MEM HOSP-VICARE AD
00758	AETNA LIFE INS CO-DELAWARE
00759	HEALTH PLAN SERVICES INC.
00760	UNITED HLTHCARE ADMINISTRATORS
00761	NYL CARE
00762	MCELROY METAL MILL INC
00763	ALLIANCE
00764	UNITED HEALTH CARE
00765	OPTIMUM CHOICE
00766	UNICARE GROUP CLAIMS
00767	CHA HEALTH
00768	UNITED HEALTHCARE
00769	LITTLE CAESAR FRANCHISE BEN PL
00770	STARBRIDGE/STAR HUMAN RES GRP
00771	BC/BS OF ROCHESTER AREA
00772	EMPHESIS
00773	KENTUCKY UTILITIES COMPANY
00774	THE GUARDIAN (WASHINGTON)
00775	LINE CONSTRUCTION BENEFIT FUND
00776	NEW YORK LIFE
00777	UNICARE
00778	BC/BS OF MINNESOTA
00779	CRAWFORD & COMPANY
00780	BLUE CROSS BLUE SHIELD OF LA
00781	PROVIDENT LFE & ACC-S.CAROLINA
00781	PROVIDENT LFE & ACC-S.CAROLINA
00782	BUNKER HILL FOODS INC
00783	CIGNA - NEW MEXICO
00784	BENEFIT CONCEPTS INSURANCE
00785	HUMANA EMPLOYERS HEALTH
00786	BC/BS OF UTICA (NEW YORK)
00787	THE CENTENNIAL LIFE INS. CO.
00788	PREFERRED HEALTH PLAN INC.
00789	BENEFIX/OLAN MILLS GR MED PLAN
00790	JEFFERSON-PILOT (BLUE RDG ADM)

00791	CUNA MUTUAL INS CO-CREDIT UNIO
00792	AMERITAS DENTAL CARE DIVISION
00793	PITTMAN AND ASSOCIATES
00794	COMMONWEALTH HEALTH ALLIANCE
00795	BENEFIT ASSISTANCE CORP
00796	COASTAL LUMBER HEALTH CARE
00797	ARAMARK
00798	VICARE
00799	PRIMARY HEALTH SERVICES
00800	ABC-ASSOC BLDRS & CONTRACTORS
00801	KEMPER NATIONAL INS COMPANY
00802	WORKMANS OIL INC.(ACS GROUP)
00803	WYNN'S
00804	THE TPA
00805	COMMUNITY HEALTH
00806	AMERICAN HEALTH SERVICES
00807	MVP SELECT CARE INC
00808	BC/BS OF DELAWARE
00809	GREAT WEST LIFE ASSUR CO.-OHIO
00810	PRIMARY PHYSICIAN CARE
00811	SOUTHEASTERN PIPETRADES
00812	ADMINISTRATIVE SERVICES INC
00813	CARDAY ASSOCIATES
00814	PHOENIX GROUP SERVICES
00815	LAND-O-SUN DAIRIES INC.
00816	TUCKER ADMINISTRATOR
00817	SELF FUNDING ADMINISTRATORS
00818	MAKSIN MANAGEMENT CO.
00819	UNITED HEALTHCARE
00820	NATIONAL ELEVATOR INDUSTRY HLT
00821	INTER-RAIL TRANS. INC.
00822	MANUS INC.
00823	PILGRIM HEALTH CARE
00824	GEORGETOWN HEALTH PLAN
00825	AETNA LIFE INS CO-HARTFORDCT
00826	DAVIS-GARVIN AGENCY
00827	DIVERSIFIED PHARM. SERVICES
00828	ADVANCED PARADIGM INC.
00829	ALLIANCE PPO
00830	PEOPLES BENEFIT LIFE INSURANCE
00831	PARTNERS OF NORTH CAROLINA INC
00832	VICARE
00833	HEALTH ALLIANCE PLAN
00834	FINDLAY INDUSTRIES
00835	ECKARD HEALTH SERVICES
00836	ADVANCE DATA SOLUTIONS
00837	PHARMACY ADVANTAGE SYSTEMS
00838	MEDCO/PAID PRECRIPTION
00839	VISION ONE
00840	ALL RISK ADMINISTRATORS INC.
00841	ADMINISTRATIVE SERV OF N.AMER
00842	AUTOMATED GRP ADMIN. INC.
00843	BENEFIT PLAN ADMINISTRATORS
00844	COOPERATIVE BENEFIT ADMIN
00845	CIGNA HEALTHCARE
00846	EXPRESS SCRIPTS INC.
00847	CIGNA HEALTH PLANS

00848	CIGNA HEALTHCARE
00849	AETNA US HEALTHCARE
00850	CIGNA HEALTHCARE
00851	RX PRIME
00852	CIGNA HEALTHCARE
00853	MET LIFE DENTAL
00854	CIGNA HEALTHCARE
00855	CIGNA HEALTHCARE
00856	CIGNA HEALTHCARE
00857	HOOKER FURNITURE
00858	CIGNA HEALTHCARE
00859	CIGNA HEALTHCARE
00860	EMPLOYEE BENEFIT CLAIMS INC.
00861	FEDERATED MUTUAL INS. CO.
00862	FIELDCREST CANNON INC.
00863	CIGNA INDEMNITY DENTAL
00864	GREAT WEST
00865	GREAT WEST
00866	GREAT WEST
00867	GROUP RESOURCES INC.
00868	JEFFERSON PILOT LIFE INS.
00869	KAISER PERMANENTE
00870	JOHN ALDEN LIFE INS. CO.
00871	KANAWHA HEALTHCARE SOLUTIONS
00872	BENESCRIPT
00873	MID-WEST NATIONAL LIFE INS CO
00874	FIRST HEALTH
00875	MAMSI
00876	DIVERSIFIED PHARMACEUTICAL SVC
00877	JOHN P. PEARL & ASSOC.
00878	OPTIMUM CHOICE
00879	PACIFIC MUTUAL
00880	PIEDMONT COMMUNITY HEALTH PLAN
00881	PRINCIPAL FINANCIAL GROUP
00882	UNIVERSAL RX
00883	ULTRA LINK
00884	DELTA DENTAL OF ARKANSAS
00885	DELTA DENTAL OF PENNSYLVANIA
00886	UNICARE
00887	UNIFI INC./MEDCOST
00888	PHARMACARE
00889	VISION SERVICE PLAN
00890	DISNEY GROUP INC.
00891	AMERICAN GROUP ADMINISTRATOR
00892	CARITEN INSURANCE CO
00893	CIGNA HEALTHCARE
00894	SO.E.PIPETRADERS H & W FD/#491
00895	JOHN DEERE HEALTHCARE
00896	ANTHEM HEALTH & LIFE (AHL)
00897	AETNA PHARMACY MANAGEMENT
00898	SPECTERA
00899	PRUDENTIAL HEALTHCARE
00900	MEDIMPACT
00901	EAGLE MANAGE CARE
00902	EXPRESS SCRIPT VALUE RX
00903	UNICARE DENTAL
00904	PRUDENTIAL HEALTHCARE DENTAL

00905	PRINCIPAL FINANCIAL GROUP
00906	PRUDENTIAL INSURANCE
00907	PRUDENTIAL INSURANCE
00908	PROFESSIONAL CLAIMS MANAGEMENT
00909	FORTIS BENEFITS INS. CO.
00910	COMMUNITY HEALTHCARE
00911	UFCW
00912	GROUP DENTAL SERVICE
00913	ARGUS HEALTH SYSTEM
00914	ADMINISTRATED SOLUTIONS INC.
00915	SHEFFIELD OLSON & MCQUEEN INC.
00916	SCRIPT CARE
00917	PIEDMONT COMMUNITY HEALTH PLAN
00918	CIGNA HEALTHCARE
00919	PRINCIPAL FINANCIAL
00920	PRINCIPAL FINANCIAL
00921	PRINCIPAL FINANCIAL
00922	PRINCIPAL FINANCIAL
00923	PRINCIPAL FINANCIAL
00924	CIGNA HEALTHCARE
00925	CIGNA HEALTHCARE
00926	UNICARE
00927	UNITED HEALTHCARE OF MIDWEST
00928	GOLDEN RULE
00929	UNICARE
00930	UNICARE DENTAL
00931	ERISA DESIGNED SYSTEMS ADMIN
00932	NATIONAL TEXTILES
00933	ALLIANZ-LIFE INSURANCE CO
00934	COMPANION LIFE
00935	MEDICHOICE
00936	SAI MEDICAL HEALTH
00937	KAISER PERMANENTE
00938	CORNING INC. HEALTH BENEFITS
00939	AON CONSULTING
00940	BLUE CROSS/BLUE SHIELD-S CAROL
00941	FIRST OPTION HEALTH PLAN
00942	AARP HC OPTIONS/UNITED HC CLAI
00943	INSURERS ADMINISTRATORS
00944	TUFTS BENEFIT ADMINISTRATORS
00945	RX NET
00946	DELMARVA UNITED F&C WKRS
00947	GROUP H PENSION ADMINISTRATOR
00948	RESERVE NATIONAL INS CO
00949	RURAL CARRIER BENEFIT
00950	FMH BENEFIT SERVICES INC.
00951	HRM CLAIM MANAGEMENT INC.
00952	THE BOARD OF PENSIONS
00953	CENTRA
00954	SIMA/SOUTHERN INSURANCE MGMT
00955	NEW ENGLAND FINANCIAL
00956	MEDICAL MUTUAL OF OHIO
00957	WELS VEBA HLTH PLAN GRP ASSOC
00958	MD HEALTH PLAN
00959	SERV-U PRESCRIPTION SERVICES
00960	SOUTH WEST INSURANCE
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GENERAL INFORMATION

A code that identifies the type of coverage an enrollee has with the third party. Allowed values in this report are 'A' = Part A, 'B' = Part B and 'RD' = Part D.

Subsystem: Financial
Business Name: N/A
Reference Name: C_CVRG_CVAL
Cobol Picture: X(02)
DB2 Data Type: CHAR(02)
Range: N/A

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BUSINESS RULES

Valid Code The data element must contain either a valid code (as defined by the domain / lookup table), or a blank.

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VALID VALUES	DESCRIPTION
A	Medicare Part A
B	Medicare Part B
C	Cancer
D	Dental
E	Not assigned
F	Home Health/Personal Care
G	Mental Health
H	Hospitalization

I	Indemnity/Accident
J	Dependent Pregnancy
K	Medicare Extended
L	Managed Care (HMO/PPO)
M	Major/Medical-Comprehensive
N	Intermediate Care Nursing Facility
O	Optical/Vision
P	Physician
Q	Chiropractor
R	Pharmacy
RD	Medicare Part D
S	Skilled Nursing
T	Transportation
U	Uninsured Absent Parent
V	Rehabilitation/Physical Medicine
W	Worker's Compensation
X	Preventive Care
Y	Medicare Part A-HMO (no longer used)
Z	Medicare Part B-HMO (no longer used)

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