This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), **Version 5010.**

1. **Title of best practice:**

   Provider Eligibility Verification

2. **Who does the best practice apply to**:

   This best practice is intended as guidance for health care providers, group purchasers (health plans, payers), intermediaries such as clearinghouses, and other interested parties.

3. **What is being addressed by the best practice:**

   Below are recommendations for providers to facilitate verifying a patient's eligibility for health coverage and benefits with a health plan, including:

   - When and how to verify;
   - Preferred methods of eligibility inquiry; and,
   - Sharing eligibility information.

4. **The loops, segments and elements, etc. the best practice applies to:**

   - ***When and How Eligibility Should Be Checked***

     Generally, the need for eligibility checking and verification is triggered when a patient is receiving or is going to receive services. Eligibility should be checked from all sources prior to a patient visit as well as every calendar month, especially for public program coverage. Ideally, eligibility transactions should not be concentrated on the first day of the month. These recommendations should be followed for all health plans including Medicare.

     Re-verify eligibility outside the normal schedule above if the patient indicates something has changed, for example:

     - New ID card, group number has changed;
     - Medicare eligibility;
     - When generating estimates requested by the patient; and,
     - Change in employment and new coverage.

- ***Preferred Methods of Eligibility Inquiry in Order of Priority A-D***

Methods	Notes
A. Electronic exchange of the HIPAA-adopted X12 v5010 270/271 Eligibility Inquiry and Response transaction	The preferred method of eligibility inquiry is the electronic exchange of the HIPAA-adopted X12 v5010 270/271 Eligibility Inquiry and Response transaction as further described in the applicable Minnesota Uniform Companion Guide. This method is preferred because it removes the chance for errors by having to re-key information. In addition: ▪ Generally, batch transactions are preferred for checking eligibility; ▪ Real-time transactions may be used as needed; ▪ Clearinghouse vendors should not submit 270 transactions unless they are requested by the provider.
B. Web Portal	May be used as needed
C. Interactive Voice Response (IVR)	Use when 270/271 or web is not available
D. Phone call (if data not available via IVR)	Call health plan customer service number as a last resort or if level of detail needed cannot be obtained via the other three methods above.

- ***Recommendation for Sharing Eligibility Data Across Care System***

  We recommend that providers centralize sharing of eligibility information across the care organization.

Visit our website at www.health.state.mn.us/facilities/ehealth/auc