FRONT DESK

# Eligibility verification cheat sheet

Verify for the exact date of service — every new patient, insurance change, or high-dollar visit. Clearinghouse first (Waystar). Portals below are the backup.

| PAYER | PORTAL | CHECK THIS |
|---|---|---|
| **BCBST / BlueCare** | essentials.availity.com | Subscriber ID, group #, PCP, copay, referral. |
| **TennCare & MCOs** | tn.gov/tenncare/providers | Confirm MCO (BlueCare, Wellpoint, or UHC Community) and PCP. |
| **Medicare (Traditional)** | mycgsmedicare.com | Current MBI. Check MA enrollment and MSP before billing. |
| **Medicare Advantage** | That MA plan's portal | Use the MA payer — do not bill traditional Medicare. |
| **UnitedHealthcare** | uhcprovider.com | Plan type, referral, and auth flags. Includes Community Plan / Dual. |
| **Aetna** | essentials.availity.com | Benefits and network status for this DOS. |
| **Cigna** | cignaforhcp.cigna.com | Eligibility, referral, and prior-auth flags. |
| **Humana / TRICARE East** | humanamilitary.com | TRICARE referrals are strict. Commercial Humana: Availity. |
| **Ambetter of Tennessee** | ambetterhealth.com/tennessee | Marketplace benefits vary. Confirm cost share before the visit. |

## BEFORE THE PATIENT IS ROOMED

- Scan card front and back. Name and DOB must match photo ID.
- Run eligibility for today's date of service — not last visit.
- Active? Deductible left? Copay for this service? Referral needed?
- Secondary insurance? Confirm order of benefits (COB).
- Note who verified, when, and the result in the chart.
- Flag termed coverage, MA vs traditional mix-ups, or missing referrals now.

PRIOR AUTHORIZATION

# When to stop and get an auth

If the portal or clearinghouse flags authorization, do not room-and-hope. High-risk services: advanced imaging, procedures, DME, injectables, therapy beyond the plan's visit limit.

### 1. Confirm it is required

Eligibility response and the payer portal both list auth/referral. Same-payer commercial vs MA vs TennCare MCO can differ.

### 2. Submit before the DOS

Need: member ID, NPI/TIN, CPT/HCPCS + ICD-10, place of service, and a short medical-necessity note. Attach signed notes.

### 3. Write down the number

Auth #, units or date span, and expiration go in the chart before the claim drops. Expired auth = denial.

### 4. If it is denied

Do not bill and hope. Call provider services or send to billing the same day with the denial reason.