

Table 120-1280 – Third Party Resource (TPR) Explanation Codes

Use in Field “9” on the CMS-1500

Single Insurance Coverage	
Use when the client has only one insurance policy in addition to DMAP coverage.	
UD	Service Under Deductible
NC	Service Not Covered by Insurance Policy
PN	Patient Not Covered by Insurance Policy
IC	Insurance Coverage Cancelled/Terminated
IL	Insurance Lapsed or Not in Effect on Date of Service
IP	Insurance Payment Went to Policyholder
PP	Insurance Payment Went to Patient
NA	Service Not Authorized or Prior Authorized by Insurance
NE	Service Not Considered Emergency by Insurance
NP	Service Not Provided by Primary Care Provider/Facility
MB	Maximum Benefits Used for Diagnosis/Condition
RI	Requested Information Not Received by Insurance from Client
RP	Requested Information Not Received by Insurance from Policy holder
MV	Motor Vehicle Accident Fund Maximum Benefits Exhausted
AP	Insurance mandated under administrative/court order through an absent parent not paid within 30 days
OT	Other (if above codes do not apply, include detailed information of why no TPR payment was made)
Multiple Insurance Coverage	
Use when the client has more than one insurance policy in addition to DMAP coverage.	
MP	Primary Insurance Paid-Secondary Paid
SU	Primary Insurance Paid - Secondary Under Deductible
MU	Primary and Secondary Under Deductible
PU	Primary Insurance Under Deductible - Secondary Paid
SS	Primary Insurance Paid - Secondary Service Not Covered
SC	Primary Insurance Paid - Secondary Patient Not Covered
ST	Primary Insurance Paid - Secondary Insurance Cancelled/Terminated
SL	Primary Paid - Secondary Lapsed or Not in Effect
SP	Primary Paid - Secondary Payment Went to Patient
SH	Primary Paid - Secondary Payment Went to Policyholder
SA	Primary Paid - Secondary Denied - Service Not Authorized or Prior Authorized
SE	Primary Paid - Secondary Denied - Service Not Considered Emergency
SF	Primary Paid - Secondary Denied - Service Not Provided by Primary Care Provider/Facility
SM	Primary Paid - Secondary Denied - Maximum Benefits Used for Diagnosis/Condition
SI	Primary Paid - Secondary Denied - Requested Information Not Received from Policyholder
SR	Primary Paid - Secondary Denied - Requested Information Not Received from Patient
MC	Service Not Covered by Primary or Secondary Insurance
MO	Other (if above codes do not apply, include detailed information of why no TPR payment was made)

This is an agreement between a *Client* and a *Provider*, as defined in OAR 410-120-0000. The client agrees to pay the provider for health service(s) not covered by the Oregon Health Plan (OHP), coordinated care organizations (CCOs) or managed care plans. For the purposes of this Agreement, *services* include, but are not limited to, health treatment, equipment, supplies and medications.

Provider section

① Provider completing this form is (*check one*):

<input type="checkbox"/> Rendering provider (<i>the provider who is providing the service</i>)	<input type="checkbox"/> Prescribing provider
<input type="checkbox"/> Hospital	<input type="checkbox"/> Pharmacy
	<input type="checkbox"/> Ancillary (<i>other</i>) provider:

② Service(s) requested: _____
 Service codes (*CDT/CPT/HCPCS/NDC*): _____

③ Expected date(s) of service (*if services are to occur over several months, please list the frequency, beginning and expected end dates*): _____

④ Condition being treated: _____

⑤ Estimated fees \$ To \$. *Check one of the following statements about these fees:*

There are no other costs that are part of the service(s).

There may be other costs that are part of the service(s) and you may have to pay for them, too. Other procedures that usually are part of the service(s) may include the following (*check all that apply*):

<input type="checkbox"/> Lab	<input type="checkbox"/> X-ray	<input type="checkbox"/> Hospital	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Other:
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⑥ As the rendering or prescribing provider:

- I have tried all reasonable covered treatments for your condition.
- I have verified that the proposed service(s) are not covered.
- I have informed you of covered treatments for your condition, and you have selected a treatment that is not covered.

As any other provider (*check one of the following statements*):

I understand that your provider has talked with you about other choices and completed a separate *Agreement to Pay* form.

Please see your provider to ask about other choices and to complete a separate *Agreement to Pay* form.

Provider name: _____ NPI: _____

Provider signature: _____ Date: _____

OHP client section

⑦ Client name: _____ DOB: _____ Client ID#: _____

⑧ I understand:

- That the services listed above are not covered for payment by OHP, my CCO or managed care plan.
- If I get the services above I agree to pay the costs. After having the services, I will get bills for them that I must pay.
- I have read the back of this form and understand my other options.

I have been fully informed by the provider of all available medically appropriate treatment, including services that may be paid for by the Oregon Health Authority (OHA) or OHA-contracted CCOs or managed care plans, and I still choose to get the specified service(s) listed above.

 Client (or representative's) signature – *Representative must have proof of legal authority to sign for this client* Date
If signed by the client's representative, print their name here:

⑨ Witness signature: _____ Date: _____
 Witness name: _____

This agreement is valid only if the estimated fees listed above do not change and the services are scheduled within 30 days of the member's signature.

Client – Keep a copy of this form for your records.

Attention OHP Client – Read this information carefully before you sign.

Before you sign you should be sure each service is not covered by OHP or your Coordinated Care Organization (CCO) or managed care plan. Here are some things you can do:

① **Check to make sure the service is not covered**

OHA, your CCO or plan will send you a Notice of Action if they do not cover a service that your provider requests. If you did not receive a Notice of Action, ask your CCO, plan or provider to send you one so you can be sure the service is not covered by OHP.

② **Request an Appeal and or Hearing**

Once you have a Notice of Action, you can request an Appeal or Hearing. Read the Notice of Action carefully. It will explain why the service was denied. It will also give you information about your right to appeal the denial or ask for a hearing.

If you also have Medicare, you may have other Appeal rights. If you have both OHP and Medicare, call 800-Medicare (800-633-4227) or TTY 711.

③ **Check to see if there are other ways to get the service**

Ask your provider if:

- They have tried all other covered options available for treating your condition.
- There is a hospital, medical school, service organization, free clinic or county health department that might provide this service, or help you pay for it.

Will your OHP benefits, or any other health insurance you may have, change soon? If so, try to find out if this service will be covered when your benefits change.

④ **Ask about reduced rates and discounts**

Ask your provider if they can offer you a reduced rate for the service or if they offer discounts for people who pay for services privately. They may have nothing to offer you, but you won't know unless you ask.

⑤ **Get a second opinion**

You may find another provider who will charge you less for the service.

Additional costs

There may be services from other providers – like hospital, anesthesia, therapy or laboratory services – that go with the service you want. You will have to pay for these, too. Ask your provider for the names and phone numbers of the other providers. Contact those providers to find out what their charges will be.

Questions?

- Call your plan or CCO's Customer Service department, or
- Call the OHP Client Services Unit at 800-273-0557, TTY 711
- Call the Public Benefits Hotline at 800-520-5292 if you would like legal advice about OHP benefits and paying for services.

Attention Provider – Relevant Oregon Administrative Rules (OARs)

Requirements of this Agreement are outlined in OAR 410-120-1280, Billing, and 410-141-3395, Member Protection Provisions. These rules can be found online at http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_tofc.html.