PA PROMISe™ EVS Response Worksheet

For Provider's Internal Use Only

Recipient Name:		Date of Service:
☐ Eligible For MA Coverage	☐ Eligible for Managed Care Coverage	☐ Ineligible for Date of Service

EVS RESPONSE

Recipient Demographics

Recipient Name: _____

Recipient ID #: _____

Gender: _____

Date of Birth: _____

MA Eligibility & Coverage

Eligibility Status ☐ Eligible ☐ Not Eligible

Category of Assistance: _____

Program Status Code: _____

Service Program Code: _____

Fee-For-Service (FFS)/Managed Care Organization (MCO)/Family Care Network (FCN)/Long Term Care Capitated Assistance Program (LTCCAP) Information (Physical Health Benefits)

Plan Name/Code: Telephone #:

Primary Care Physician (PCP) Name	Telephone Number	Begin & End Dates
PCP #1:	( ) -	/
Primary Care Case Manager (PCCM) Name	**Telephone Number**	**Begin & End Dates**
PCCM Name: _____	( ) -	/

MCO Behavioral Health Benefits

Plan Name/Code: _____ Telephone #: ( ) -

Third Party Liability (TPL)

Carrier Name/Type	Address of Carrier	Policy Holder Name & Number	Group No.
TPL #1 Court Ordered: ☐ Yes ☐ No	_____ _____ _____	Name: _____ Policy No.: _____ Begin Date: _____ End Date: _____	_____

Third Party Liability (TPL) *(continued)*

TPL #2 Court Ordered: ☐ Yes ☐ No	_____ _____ _____	Name: _____ Policy No.: _____ Begin Date: _____ End Date: _____	_____
TPL #3 Court Ordered: ☐ Yes ☐ No	_____ _____ _____	Name: _____ Policy No.: _____ Begin Date: _____ End Date: _____	_____

**EVS provides up to three third party resources. Always ask the recipient if there is any other available health insurance coverage.*

Lock-In/Restricted Recipient Information

Is the recipient restricted?	☐ Yes ☐ No
Lock-In Provider's Type:	
Name of Lock-In Provider:	
Lock-In Provider's Telephone No.:	
Begin & End Dates: (If different from inquiry dates)	

Is the recipient restricted?	☐ Yes ☐ No
Lock-In Provider's Type:	
Name of Lock-In Provider:	
Lock-In Provider's Telephone No.:	
Begin & End Dates: (If different from inquiry dates)	

Please Note: *Restrictions* ***do not*** *apply to emergency services.*

Early Periodic, Screening, Diagnosis, and Treatment (EPSDT)

Last EPSDT Screening Date: ____/____/____

**If providing an EPSDT Screen, please refer to the current Pennsylvania Children's Checkup (EPSDT) Program Periodicity Schedule and Coding Matrix Periodicity Chart to determine the recipient's EPSDT screening eligibility.*

Dental

Last Dental Exam Date: ____/____/____

This date is applicable to a dentist providing a dental exam.