# 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<br><br>Court Ordered:<br>☐ Yes ☐ No | _____<br>_____<br>_____ | Name: _____<br>Policy No.: _____<br>Begin Date: _____<br>End Date: _____ | _____ |
| | | | |

## Third Party Liability (TPL) *(continued)*

| | | | |
|---|---|---|---|
| TPL #2<br><br>Court Ordered:<br>☐ Yes ☐ No | _____<br>_____<br>_____ | Name: _____<br>Policy No.: _____<br>Begin Date: _____<br>End Date: _____ | _____ |
| TPL #3<br><br>Court Ordered:<br>☐ Yes ☐ No | _____<br>_____<br>_____ | Name: _____<br>Policy No.: _____<br>Begin Date: _____<br>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:<br>(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:<br>(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.*