SECTION B – 10A – AMBULANCE – BASE 1 SCREEN

PBP 2008 Data Entry System - #10a Ambulance - Base 1

File

RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT

Enhanced Benefits are not applicable for this Service Category.

Maximum Plan Benefit Coverage is not applicable for this Service Category.

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
- Yes
- No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Is there an enrollee Coinsurance?
- Yes
- No

Indicate the Minimum Coinsurance percentage for Medicare Covered Benefits:

Indicate the Maximum Coinsurance percentage for Medicare Covered Benefits:

Is this Coinsurance waived if admitted to hospital?
- Yes
- No

Select the Coinsurance Coverage Basis for Medicare Covered Benefits:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Medicare Fee-for-Service Charge Structure
- Other, describe

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

Is there an enrollee Copayment?
- Yes
- No

Indicate the Minimum Copayment amount for Medicare Covered Benefits:

Indicate the Maximum Copayment amount for Medicare Covered Benefits:

Is this Copayment waived if admitted to hospital?
- Yes
- No

SECTION B – 10A – AMBULANCE – BASE 2 SCREEN

PBP 2008 Data Entry System - #10a Ambulance - Base 2

File

Enrollee must receive Authorization for non-emergency Medicare services from one or more of the following:

- [ ] None
- [ ] Primary Care Physician (Internist/Family Practice, General Practice)
- [ ] Physician Specialist
- [ ] Organization Medical Director/Utilization Management/Utilization Review
- [ ] Other, describe

Is a referral required for Ambulance Services?

- ( ) Yes
- ( ) No

Notes (Optional):

Import Text

SECTION B – 10B – TRANSPORTATION – BASE 1 SCREEN

PBP 2008 Data Entry System - #10b Transportation - Base 1

File

RIGHT CLICK HERE FOR DESCRIPTION OF BENEFIT

Do you offer any Mandatory or Optional Supplemental Benefits?
- Yes
- No

Select enhanced benefit:
- Plan-approved Location
- Any Location

Select type of benefit for Plan-approved Location:
- Mandatory
- Optional

Is this benefit unlimited for number of trips for Plan-approved Location?
- Yes
- No

Indicate number of trips for Plan-approved Location:

Select Plan-approved Location Trips periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select Type of Transportation for Plan-approved Location:
- One-way
- Round Trip

Select Mode of Transportation for Plan-approved Location:
- Taxi
- Bus/Subway
- Van
- Other, describe

Select type of benefit for Any Location:
- Mandatory
- Optional

Is this benefit unlimited for number of trips for Any Location?
- Yes
- No

Indicate number of trips for Any Location:

Select Any Location Trips periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select Type of Transportation for Any Location:
- One-way
- Round Trip

Select Mode of Transportation for Any Location:
- Taxi
- Bus/Subway
- Van
- Other, describe

SECTION B – 10B – TRANSPORTATION – BASE 2 SCREEN

PBP 2008 Data Entry System - #10b Transportation - Base 2

File

Is there a service-specific Maximum Plan Benefit Coverage amount?
- Yes
- No

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Select the Coverage Basis for Maximum Plan Benefit Coverage:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Other, describe

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
- Yes
- No

Indicate Maximum Enrollee Out-of-Pocket Cost amount:

Select Maximum Enrollee Out-of-Pocket Cost periodicity:
- Every three years
- Every two years
- Every year
- Every six months
- Every three months
- Other, describe

Is there an enrollee Coinsurance?
- Yes
- No

Indicate Coinsurance percentage:

Select the Coinsurance Coverage Basis:
- Published Fee Schedule
- MA Organization Developed Fee Schedule
- MA Organization Developed Cost Structure
- Other, describe

Is there an enrollee Deductible?
- Yes
- No

Indicate Deductible Amount:

SECTION B – 10B – TRANSPORTATION – BASE 3 SCREEN

PBP 2008 Data Entry System - #10b Transportation - Base 3

File

Is there an enrollee Copayment?
- ○ Yes
- ○ No

Indicate Copayment amount per trip:

____

Enrollee must receive Authorization from one or more of the following:
- ☐ None
- ☐ Primary Care Physician (Internist/Family Practice, General Practice)
- ☐ Physician Specialist
- ☐ Organization Medical Director/Utilization Management/Utilization Review
- ☐ Other, describe

Is a referral required for Transportation Services?
- ○ Yes
- ○ No

Notes (Optional):

Import Text