GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Director

DHCF Transmittal No. 10-05

TO: District of Columbia Medicaid Providers

FROM: Julie Hudman, PhD
Director
Department of Health Care Finance

DATE: February 1, 2010

SUBJECT: Reimbursement of Out-of-Pocket Expenditures for Non-Managed Care Medicaid Beneficiaries

---

In keeping with requirements of the Salazar Court Order, this is the annual transmittal of the [Revised] Notice of Reimbursement Procedures for Non-Managed Care Class Members' Out-of-Pocket Medical Expenses, for D.C. Medicaid fee-for-service beneficiaries who paid for drug prescriptions, doctor visits, or hospitalizations that should have been paid by Medicaid. The Notice includes a Medicaid Reimbursement Form to be used by fee-for-service beneficiaries who seek reimbursement.

To help fee-for-service beneficiaries who may have had such expenditures, you are required to make this information available to your patients.

In order to be considered for reimbursement, fee-for-service beneficiaries must submit their Reimbursement Requests no later than six months after the expense was incurred, or no later than six months from the date they learned of their eligibility for Medicaid. In addition, beneficiaries must:

1. Complete the attached Medicaid Reimbursement Form on which they provide name, address, telephone number, Social Security number, date of birth, date(s) of services provided, providers of the services, the medical services for which they paid, and the amounts paid.

2. Attach receipt(s) from the provider(s) showing payment for the medical service(s), if available. (If not available, provider(s) can give the patient a copy).

825 North Capitol Street, N.E, Suite 5135, Washington, D.C.20002 FAX: (202) 442-4790

3. If no receipt is available, the beneficiary may provide a sworn statement that the information provided is true and accurate with an explanation of why the receipt is not included. All claims are reviewed, researched, and documented. Reimbursements can only be made for services that should have been paid by Medicaid. (Note: Accuracy is important in the payment of any and all Medicaid claims, "…any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws")

When the District of Columbia sends an eligibility notice to a beneficiary, the dates of eligibility are specified. A beneficiary's eligibility may include the three months prior to filing the Medicaid application, or the time after submitting the application while waiting for a decision, and any time during which the recipient was improperly denied eligibility for services.

If you have questions or need additional information, please call the Medicaid Recipient Claims Research Team, Health Care Operations Administration, Department of Health Care Finance, on (202) 698-2009.

Attachment

TO ALL DISTRICT OF COLUMBIA MEDICAID RECIPIENTS
WHO PAID FOR MEDICAL EXPENSES THAT SHOULD HAVE BEEN PAID BY MEDICAID

If you do not speak and/or read English, please call (202) 442-5988 between 8:15 a.m. and 4:45 p.m. A representative will assist you.

Si no habla o lee inglés, llame al (202) 442-5988 entre las 8:15 a.m. y las 4:45 p.m. Un representante se complacerá en asistirle.

ቺዩኢጻኣት ቀዩቀ ኳልወተዝዞም ቺቴ/ነወሐ ኳልኽተቃቁጵ ቺተጵ: ቺዥፋቅፕ ቺ8:15 ሩኛቴ ቺራቺ ሐሯቅፕ 4:45 ሩኛቴ ቂነጵ ዞጽኗፅ ነጵራዝ ቺቂቾኖ ቁ (202) 442-5988 ወዋነጿጵሀዩ:: ኳት ቅነችወ ወማዌጹኖቆሀ::

Nếu bạn không nói và/hoặc đọc tiếng Anh, xin gọi (202) 442-5988 từ 8 giờ 15 sáng đến 4 giờ 45 chiều. Sẽ có người đại diện giúp bạn.

如果您不能講和/或不能閱讀英語，請在上午 8:15到下午 4:45之間給

(202) 442-5988 打電話，我們會有代表幫助您。

영어로 대화를 못하시거나 영어를 읽지 못하시는 경우, 오전 8시 15분에서 오후 4시 45분 사이에 (202) 442-5988번으로 전화해 주시기 바랍니다. 담당 직원이 도와드립니다.

Si vous ne parlez pas ou lisez l'anglais, s'il vous plaît appeller (202) 442-5988 entre 8:15 du matin et 4:45 du soir. Un représentant vous aidera.

If you paid for drug prescriptions, doctor visits, or hospitalizations during a time that you were eligible for Medicaid, you may be able to be reimbursed for the expenses.

REQUIREMENTS: You may be eligible for reimbursement if during a period of time you or a family member were eligible for Medicaid, if:

a. You paid for drug prescriptions, doctor visits, or hospitalizations; or
b. You are still paying a bill or being asked to pay a bill by a pharmacy, clinic, doctor or hospital for drug prescriptions, doctor visits, or hospitalizations.

If you believe that you are entitled to reimbursement, you must request reimbursement within 6 months of the date you went to the pharmacy, clinic, doctor or hospital, or within 6 months of the date you learned you were eligible for Medicaid.

DEFINITION OF "ELIGIBLE FOR MEDICAID": The period of time for which you are "eligible for Medicaid" and may be eligible for reimbursement means:

1. The dates that the District of Columbia stated you (and/or your family members) were eligible for Medicaid.
2. The 3 months before you submitted your application for Medicaid (and you were later found eligible).
3. The time after you filed your application for Medicaid and were waiting for a decision (and you were later found eligible).
4. Any time you were improperly denied eligibility or services:
    a. If the District of Columbia improperly stopped your eligibility at the time of recertification.
    b. If the pharmacy, clinic, hospital, or doctor's office required you to pay because they said you were not on Medicaid when you actually were.

IN ORDER TO BE REIMBURSED, YOU MUST:

1. Complete the enclosed Medicaid Reimbursement Form.
2. Attach the receipt from the doctor, clinic, hospital or pharmacy that shows the expenses you paid.
3. If you do not have a receipt from the doctor, clinic, hospital or pharmacy, you may provide a signed and dated letter explaining why you do not have the receipt.
4. Submit the Medicaid Reimbursement Form with the receipt(s) (or the letter explaining why you do not have a receipt) to the address on the Medicaid Reimbursement Form.
5. **Remember** that you have 6 months from the date you went to the pharmacy, clinic, doctor or hospital or from the date you learned you were eligible for Medicaid to pay the expense, to submit the Medicaid Reimbursement Form. If you do not have all of the information, you should submit as much information as you have available.
6. Reimbursement will only be made for expenses that should have been paid by Medicaid. You should carefully review the documents you submit to be sure that they are fully accurate.

IF YOU HAVE QUESTIONS, OR IF YOU NEED HELP COMPLETING THE FORM OR OBTAINING REQUESTED INFORMATION CONTACT:

- The Medicaid recipient Claims Research Team of the D.C. Department of Health Care Finance (DHCF) at (202) 698-2009.

- Terris, Pravlik & Millian, LLP, 1121 12th Street, NW, Washington, D.C. 20005, (202) 682-0578, who will provide you with free legal assistance.

A DECISION ON YOUR REIMBURSEMENT CLAIM MUST BE MADE WITHIN 90 DAYS:

- The Medicaid Recipient Claims Research Team must make a decision on your reimbursement claim within 90 days from the time you file your claim. If no decision is made within those 90 days, you claim will be treated as valid, and you will be paid within 15 days after the end of the 90-day period.

- If you are not satisfied with the decision of the Medicaid Recipient Claims Research Team, you have a right to a fair hearing. You may request a fair hearing by calling (202) 442-9091. If you are not satisfied with the result of the fair hearing, you may appeal to the United States District Court of the District of Columbia within 30 days. You may obtain free legal assistance to help you present your case at the fair hearing or at the appeal by contacting Terris, Pravlik & Millian, LLP, 1121 12th Street, NW, Washington, D.C. 20005, (202) 682-0578.

MEDICAID REIMBURSEMENT FORM

If you do not speak and/or read English, please call (202) 442-5988 between 8:15 a.m. and 4:45 p.m. A representative will assist you.

Si no habla o lee inglés, llame al (202) 442-5988 entre las 8:15 a.m. y las 4:45 p.m. Un representante se complacerá en asistirle.

ቸዮኧጳኣት ቀዩቀ ኌልወተዠዙም ቸቴ/ነወሐ ኌልኸተቃቁጵ ቼተጵ: ቼዥሩቅፕ ቼ8:15 ሩኖቴ ቸራቼ ሐሯቅፕ 4:45 ሩኖቴ ቷነጵ ዘጵኧዕ ነጵራዠ ቸቴቾኖ ቴ (202) 442-5988 ወዋነጟጵሀዩ:: ኌት ቅነችወ ወማዊጵኖቶሀ::

Nếu bạn không nói và/hoặc đọc tiếng Anh, xin gọi (202) 442-5988 từ 8 giờ 15 sáng đến 4 giờ 45 chiều. Sẽ có người đại diện giúp bạn.

如果您不能講和/或不能閱讀英語，請在上午 8:15到下午 4:45之間給

（202）442-5988 打電話，我們會有代表幫助您。

영어로 대화를 못하시거나 영어를 읽지 못하시는 경우, 오전 8시 15분에서 오후 4시 45분 사이에 (202) 442-5988번으로 전화해 주시기 바랍니다. 담당 직원이 도와드립니다.

Si vous ne parlez pas ou lisez l'anglais, s'il vous plaît appeller (202) 442-5988 entre 8:15 du matin et 4:45 du soir. Un représentant vous aidera.

Complete and return this form no later than 6 months after you went to the pharmacy, clinic, doctor or hospital and paid for your services, or within 6 months of the date you learned you were eligible for Medicaid, to:

Recipient Claims Research Team
D.C. Department of Health Care Finance
2100 Martin Luther King, Jr. Avenue, SE, Suite 302
Washington, D.C. 20020

Your Name: _____

Daytime Phone: _____ **Evening Phone:** _____

Mailing Address: _____

_____

Social Security Number: _____ **Date of Birth:** _____

Please provide as much of the following information as possible. You may use additional paper if you need to. For example, if you are seeking reimbursement for expenses from both a doctor and a pharmacy, it may be easier to write the information on additional paper.

For each expense (drug prescription, doctor visit or hospitalization), provide:

(1) Name of person (you or family member) for whom Medicaid did not pay for drug prescriptions, doctor visits or hospitalizations:

(2) Date (or approximate date) of the expense.

(3) Type of expense (drug prescription, clinic, doctor visit or hospitalization):

(4) Name and address of pharmacy, clinic, doctor or hospital:

(5) How much money you spent. Attach a copy of your receipt if you have it. If you do not have a receipt, provide a signed and dated letter explaining why you do not have it.

(6) If you are still paying money on a bill or being asked to pay on a bill that you think should have been paid by Medicaid, explain here. Attach a copy of any letters or bills you have that a pharmacy, clinic, doctor or hospital sent to you. If you received a letter from a credit collection company concerning the bill, also attach that letter.

I swear, and declare under penalty of perjury that the statements I have made above and on any attached documents are true and correct.

Signature: _____ **Date:** _____