GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
Medical Assistance Administration

Office of the Senior Deputy Director

D.C. Medical Assistance Program
Transmittal No. 01 - 02

TO: **District of Columbia Medicaid Providers**

FROM: **Herbert H. Weldon, Jr.**
Senior Deputy Director for Health Care Finance

RE: **Reimbursement of Out-of-Pocket Expenditures**

DATE: **February 15, 2001**

In keeping with requirements of the Salazar Court Order, this is an annual transmittal of the attached Notice of Reimbursement Procedures for Class Members' Out-of-Pocket Expenses, for D.C. Medicaid recipients who paid for drug prescriptions, doctor visits, or hospitalizations that should have been paid by Medicaid.

To help persons who may have had such expenditures, you are required to make this information available to your patients.

In order to be considered for reimbursement, recipients must submit their requests no later than six months after the expense was incurred or by April 1, 2001 for any claims which date back to March 2, 1990, and:

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 a receipt from the provider showing payment for the medical service(s), if available. (If not available, most providers will give the patient a copy.)

3. In lieu of a receipt from the provider(s), provide a sworn statement that the information provided is true and accurate with an explanation of why no receipt is included. All claims are reviewed, researched, and documented. (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.")

If you have questions, please call the Recipient Claims Research Team of the D.C. Medical Assistance Administration, Program Operations, at (202) 698-2009.

825 North Capitol Street, N.E., Suite 5135, Washington, D.C. 20002 (202) 442-5988 FAX: (202) 442-4790

ATTACHMENT A

UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA

OSCAR SALAZAR, JR. et al.,	:	
Plaintiffs	:	
v.	:	**Civil Action No. 93-452 (GK)**
DISTRICT OF COLUMBIA et al.	:	
Defendants.	:	

SUMMARY NOTICE OF REIMBURSEMENT PROCEDURES
FOR CLASS MEMBERS' OUT-OF-POCKET EXPENSES

TO: ALL PERSONS IN THE DISTRICT OF COLUMBIA WHO PAID MONEY FOR DRUG PRESCRIPTIONS, DOCTOR VISITS, OR HOSPITALIZATIONS THAT SHOULD HAVE BEEN PAID BY MEDICAID SINCE MARCH 2, 1990:

THIS NOTICE IS GIVEN TO INFORM YOU OF A COURT ORDER THAT MAY AFFECT YOUR RIGHTS. PLEASE READ THIS NOTICE CAREFULLY.

YOU MAY BE ENTITLED TO BE REPAID ANY MONEY YOU SPENT FOR DRUG PRESCRIPTIONS, DOCTOR VISITS, OR HOSPITALIZATIONS IF YOU HAVE BEEN ON MEDICAID AT ANY TIME FROM MARCH 2, 1990, UNTIL THE PRESENT TIME. IF YOU PAID FOR DRUG PRESCRIPTIONS, DOCTOR VISITS, OR HOSPITALIZATION DURING THIS PERIOD THAT SHOULD HAVE BEEN PAID BY MEDICAID, YOU HAVE THE RIGHT TO BE REPAID THE MONEY YOU SPENT.

IN ORDER TO BE REPAID THE MONEY YOU SPENT FOR DRUG PRESCRIPTIONS, DOCTOR VISITS, OR HOSPITALIZATIONS, YOU MUST FILL OUT A "MEDICAID REIMBURSEMENT FORM" WHICH IS ATTACHED.

NOTICE IS HEREBY GIVEN, pursuant to District Civil Action No. 93-452 and the Order of the United States District Court for the District of Columbia dated July, 1997, that all persons eligible for Medicaid since March 2, 1990, who paid for drug prescriptions, doctor visits, or hospitalizations at a time when they were eligible for Medicaid will be paid back for those expenses.

I. SUMMARY DESCRIPTION OF THE ORDER

All class members have the right to be repaid any money they spent from March 2, 1990, to the present, on drug prescriptions, doctor visits, or hospitalizations at a time that they were eligible for Medicaid and the three (3) months prior to their Medicaid application. This means that you are entitled to repayment (1) if you spent money on drug prescriptions, doctor visits, or hospitalizations while you were waiting for a decision on your Medicaid application (and you were later found eligible), (2) in the three months prior to your application for Medicaid (if you were later found eligible), (3) if you were improperly cut-off from Medicaid at recertification and had to spend your own money on drug prescriptions, doctor visit, or hospitalizations or (4) if the pharmacy, clinic, doctor's office or hospital said that you were not on Medicaid when you actually were and you had to spend money for drug prescriptions, doctor visits, or hospitalizations for a family member (such as a child) who was eligible for Medicaid, you are also entitled to be repaid that money. You must submit your request to be repaid by April 1, 2001 or six months after the expense was incurred, whichever is later.

II. SUMMARY OF PROCEDURES

1. Class members are to submit the "Medicaid Reimbursement Form" with supporting documentation to the "Claims Research Team,"Medical Assistance Administration, 2100 Martin Luther King Jr., Ave., SE, Washington, D.C. 20020. The form should include the following supporting documentation, if it is available:

- A completed Medicaid Reimbursement Form which gives your name, address, telephone number (if you have one), Social Security number, date of birth, states the date the service was provided, the provider of the service, the type of medical service you paid for and the amount you paid.
- A receipt from the provider showing payment for the medical services (s), if available.
- If you do not have a receipt from the provider, you must submit a sworn statement that the information you are giving is true and accurate, and explaining why you do not have the receipt.

However, do not delay submitting your claim if you do not have all requested information. If you delay, you may lose your right to be repaid the money you spent. Provide as much information as you have available.

2. 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. Medical Assistance Administration at (202) 698-2009; or
- Terris, Pravlik & Millian, 1121 12th Street, NW, Washington, D.C. 20005, (202) 682-0578. All legal advice will be provided to you free of charge.

3. Medicaid reimbursement will be subject to the following: (a) you (or your family member) were eligible for Medicaid at the time medical service was given; (b) the drug prescription, doctor visit or hospitalization was covered under Medicaid; and (c) the reimbursement request is submitted by April 1, 2001 or six months after the medical expense was incurred, whichever is later.

4. The Medicaid "Recipient Claims Research Team" is required to decide your claim within 90 days from the time you file. If no decision is made within that 90-day time period, your claim will be treated as valid, and will be paid within 15 days after the end of the 90-day time period.

5. 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) 724-5431 or (202) 724-5475. If you are not satisfied with the result of the fair hearing, you will have 30 days to appeal to the United States District Court for the District of Columbia. You may obtain free legal assistance to help you present your claim at the fair hearing or during the appeal by contacting Terris, Pravlik & Millian, 1121 12th Street, NW, Washington, D.C. 20005, (202) 682-0578.

By order of the United States District Court for the District of Columbia.

DATED: September 15, 1997 /s/ Gladys Kessler

THE HONORABLE GLADYS KESSLER
UNITED STATES DISTRICT JUDGE

NOTICE DATE: September 15, 1997
AMENDED: December 7, 1999 (change deadline date for submission of claims dating back to March 2, 1990 from June 30, 1998 to April 1, 2001)

MEDICAID REIMBURSEMENT FORM

Complete and return this form no later than April 1, 2001 or six months after the expense was incurred, whichever is later, with supporting information and receipts (if available) for the drug prescriptions, doctor visits or hospitalizations to: Recipient Claims Research Team
Medical Assistance Administration
2100 Martin Luther King, Jr. Ave., SE
Washington, D.C. 20020

Your Name: ____________________

Daytime Phone: ____________ Evening Phone: ____________

Mailing Address: ____________________

____

Social Security Number: ____________ Date of Birth: ____________

(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 drug prescriptions, doctor visits or hospitalizations for you or family member that Medicaid did not pay:

(3) What type of medical service (drug prescriptions, doctor visits or hospitalizations) did you or family member receive?

(4) What was the name and address (if available) of the pharmacy, doctor or hospital?

(5) How much money did you spend? Attach a copy of your receipt if you have it. If you do not have your receipt, explain why not.

(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 and attach a copy of any letters of bills you have that a pharmacy, doctor or hospital sent to you or you sent to it.

You may use additional paper if you need to.

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

Signature: ____________________ Date ____________