NEW YORK STATE DEPARTMENT OF HEALTH
Office Of Medicaid Management

ATTACHMENT VIII

REIMBURSEMENT DETAIL FORM/PAID BILLS

Aliessa/Adamolekum v. Novello

Recipient Name: _____ Social Security #: _____ Case Type: _____ CIN #: _____Case #: _____

Recipient Address: _____ Eligible: From: _____To: _____ Eligible: From: _____To: _____

Local District: _____ Eligible: From: _____To: _____ Eligible: From: _____To: _____

APPROVED PAID BILLS AND AMOUNT OF PAYMENT							DENIED PAID BILLS AND WHY WE WILL NOT PAY THIS BILL		
Date of Service (MO/DAY/YR)	Name and Address of Service Provider	Description of Service Provided	Amount Of Bill	Amount You paid	Amount of Reimbursement we will pay you ($)	3 months Retro Eligibility Period: Payment Limited to Medicaid Rate ($)	Not a covered Service (√)	You did not show that this bill was paid. (√)	OTHER: (Describe other reason that bill is not paid)

Subtotal $_____ + $_____ = Total $_____

I certify that the above-named recipient is eligible for

Medical Assistance benefits as a member of the Aliessa/Adamolekun v. Novello class.
Court Case Name

Check Amount $_____Date_____

Date Completed _____ Signature of Local District Eligibility Worker **X**_____

Authorized signature _____

DIRECTIONS FOR LDSS/MAP WORKER TO COMPLETE THE "REIMBURSEMENT DETAIL FORM/PAID BILLS"

Enter the demographic information across the top of the form; Recipient name, recipient address, Social Security Number, Case type, CIN number, Case number, local district, eligible: "FROM" and "TO" lines (Note: There may be multiple periods of coverage).

A). APPROVED PAID BILLS AND AMOUNT OF PAYMENT

The worker will enter:

- **Date of Service**: The month, day and year the service was provided.
- **Name and Address of Service Provider**;
- **Description of Service Provided**;
- **Amount of Bill**;
- **Amount You Paid:** This is the "out-of-pocket" dollar amount paid by the class member.
- **Amount of Reimbursement We Will Pay You:** This is the dollar amount Medicaid will pay to the class member i.e. the full amount of the out-of-pocket expenses. The worker will continue to list all Paid bills and add up the column "Amount of Reimbursement We will Pay You", then enter the total dollar amount on the line **"SUBTOTAL $_____."**
- **3 months Retro-eligibility Period:** Payment is limited to the Medicaid Rate: Enter the dollar amount of the Medicaid rate on the line **"SUBTOTAL $_____."**
- Add the two SUBTOTAL lines together and enter the total dollar amount on the line **"Total $_____."**

FOR PAID BILLS, THERE ARE TWO OPTIONS FOR PROCESSING CLAIMS

1) For those districts that issue their own checks:

- Complete the **"Notice of Decision on Paid/Unpaid Medical Bills"**;
- The district must add up and total the amount to be reimbursed to the class member on the **"Reimbursement Detail Form/Paid Bill**s" attaching all copies of paid bills for which reimbursement is being requested;
- Date and sign the certification at the bottom of the page;
- Issue the check in the amount due; and
- Mail the "**Notice of Decision on Paid/Unpaid Medical Bills**" and the "**Reimbursement Detail Form/Paid Bills,**" with attached copies of paid bills and check to the class member.

2) For those districts that do not issue their own checks:

- Complete the **"Notice of Decision on Paid/Unpaid Medical Bills"**;
- The district must add up and total the amount to be reimbursed to the class member on the **"Reimbursement Detail Form/Paid Bills"** attaching all copies of paid bills for which reimbursement is being requested;
- Sign and date the certification at the bottom of the page;
- Mail the "**Notice of Decision on Paid/Unpaid Medical Bills**" and "**Reimbursement Detail Form/Paid Bills,**" with attached copies of paid bills to the class member; and
- Mail the "**Reimbursement Detail Form/Paid Bills,**" attaching copies of all paid bills and proof of payment to:

New York State Department of Health
Medicaid Financial Management Unit
Attention: Tom Grestini
Corning Tower Room 1237
Albany, New York 12237

- The Medicaid Financial Management Unit will issue the check to the class member.
- The Medicaid Financial Management Unit signs and retains for its files the **"Reimbursement Detail Form/Paid Bills"** as well as copies of all paid bills and proof of payment for these bills.
- The Medicaid Financial Unit will provide a quarterly report to the LDSS identifying claims processed.

B). DENIED PAID BILLS AND WHY WE WILL NOT PAY THIS BILL

The worker will enter the appropriate information in the columns:

- **Not a Covered Service:** Indicate by placing an "X" or check (√) in this box.
- **You Did Not Show That This Bill Was Paid:** Indicate by placing an "X" or check (√) in this box.
- **Other:** Describe any other reason why the bill is not paid.

The worker must date and sign the "X_____" line certifying that the recipient is eligible for Medical Assistance benefits as a member of the Aliessa/Adamolekun v. Novello class.

Retain a copy of this form and all bills for the Local District of Social Service's case record.