Medicaid Medical Support Transmittal

County Name ______________________**WMS Case Number**____________________ **Date** __________________________________
To _____________________________ **Unit/Agency** __________________________ **Telephone #**____________________________
From ____________________________**Unit/Agency**___________________________**Telephone #**____________________________

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PART 1: PERSONAL INFORMATION

Custodial Parent (CP) Name ________________________________ **CP SSN** ______________ **CP Date of Birth** ____________________
CP Address____ **CP Telephone No**________________
____ **CP Monthly Gross Income $**__________________
Medicaid Case Name___________________________________ **Medicaid Case Number**____________________

Noncustodial Parent (NCP) Name _____________________________ **NCP SSN** ______________ **NCP Date of Birth** ____________________
NCP Address ____ **NCP Telephone No**________________________________
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PART 2: PURPOSE FOR TRANSMITTAL

☐ **New Case** ☐ **New/Updated MA Information** ☐ **Recovery of Fee-for-Service Medicaid Costs**
☐ **Addition to Existing Case** (see child listed in Part 3)
☐ **Good Cause Claim Request:** Child #____ ☐ **Referred to Domestic Violence Liaison:** Child #____ Date__________
☐ **Good Cause Reviewed by Medicaid:** Child #____ ☐ Approved by Medicaid - Date __________ ☐ Not Approved
☐ **Child # ___ already in case is now exempted**
☐ **Temporary Suspension of Medical Support Action due to**:
☐ Pregnancy - EDC ___________
☐ NCP in receipt of Medicaid
☐ Other ____
☐**Resume Medical Support Action due to**:
☐ Pregnancy /Post Partum-End Date ________________
☐ Other ____
☐ **Change in Status/Case (Identify Change):** _____________________________________

PART 3: CHILD INFORMATION FOR THE NCP NAMED IN PART 1 ☐ **Check if additional children are on separate transmittal**

Note: Check box after child's name/line #/CIN only if EXEMPT from Medical Support Requirements

CHILD 1

Child Name ________________________________ **WMS Line #**_______ **CIN** ___________________ ☐ **EXEMPT**

☐ **Establish Cash Medical Support Obligation** ☐ **Paternity Establishment Only**

Coverage type: ☐ Fee-for-Service ☐ Managed care – Monthly Premium: $____________

Coverage Dates: Start_____________ ☐Current coverage **OR** ☐ Medicaid Closing Date ______________

☐ **Expenses for Prior Periods/Years** Period/Year _____________ ☐ Managed care premium **OR** ☐ Fee-for-Services expenditures for child: $__________

Period/Year _____________ ☐ Managed care premium **OR** ☐ Fee-for-Services expenditures for child: $__________

☐ Check if additional years attached

☐ **Recovery of Fee-For-Services Costs**: For the period from ___________ to ___________ Total paid on behalf of child: $____________

Billing notice(s) of medical support sent to NCP on: _________________ Total payment(s) received from NCP $ _________ Net due: ___________

☐ Copy of billing notice(s) to NCP attached

☐ **Confinement Costs:** ☐ Pregnancy Fee-For-Service costs $________ **OR** ☐ Pregnancy capitation payments total $______

CHILD 2

Child Name ________________________________ **WMS Line #**_______ **CIN** ___________________ ☐ **EXEMPT**

☐ **Establish Cash Medical Support Obligation** ☐ **Paternity Establishment Only**

Coverage type: ☐ Fee-for-Service ☐ Managed care – Monthly Premium: $____________

Coverage Dates: Start_____________ ☐Current coverage **OR** ☐ Medicaid Closing Date ______________

☐ **Expenses for Prior Periods/Years** Period/Year _____________ ☐ Managed care premium **OR** ☐Fee-for-Services expenditures for child: $__________

Period/Year _____________ ☐ Managed care premium **OR** ☐Fee-for-Services expenditures for child: $__________

☐Check if additional years attached

☐ **Recovery of Fee-For-Services Costs**: For the period from ___________ to ___________ Total paid on behalf of child: $____________

Billing notice(s) of medical support sent to NCP on: _________________ Total payment(s) received from NCP $ _________ Net due: ___________

☐ Copy of billing notice(s) to NCP attached

☐ **Confinement Costs:** ☐ Pregnancy Fee-For-Service costs $________ **OR** ☐ Pregnancy capitation payments total $_______

Attach additional pages if more than two children are associated with the NCP

PART 4: CERTIFICATION

I hereby certify that: 1) I am an employee of the ______________ County Department of Social Services, which is required by the NYS Social Services Law to provide correct and complete information from its records in response to requests by the Support Collection Unit; 2) the information in this transmittal was taken from records of the ___________ County Department of Social Services; 3) such information is maintained in the regular course of business; 4) it is the regular course of such business to maintain such information; and 5) a memorandum or record of the information was made at the time of the act, transaction, occurrence or event, or within a reasonable time thereafter. I certify that I have been designated by the Commissioner of Social Services for the purpose of making this certification.

Dated: ____________ **Signature:** ____ **Title:** ___________________________________

Print Name: ____ **Telephone #:**___________________________