LDSS-3183 (9/13)

PROVIDER or MANAGED LONG TERM CARE PLAN/RECIPIENT LETTER

(Financial Obligation of Recipient Toward Medical Expenses)

To: (Name/Address of Provider or Managed Long Term Care Plan)	**Concerning: (Name/Address of Recipient)**	**CIN #**

This report is to advise the Medicaid provider or Managed Long Term Care plan and the Medicaid recipient of the sharing of certain costs between the recipient and the Medicaid program.

☐ The Medicaid provider named on this form must take note of all payment exclusions/limitations as noted on this form before billing the Medicaid program for this recipient.

Medicaid has been authorized for the above recipient for the period of_____. This authorization is for:
__ Outpatient Care Only __ All Available Benefits (Inpatient and Outpatient)

This decision was based on the fact that you, as the recipient, had income/resources in excess of the eligibility level, as you were advised in your Notice of Decision, and had to incur medical costs at least equal to the amount of this excess to become eligible for Medicaid. The unpaid bills which you used to become eligible are listed below. These bills are your responsibility and are not to be billed by your medical provider to the Medicaid program.

Bill Date	Date of Service	Patient's Name/Account Number	Amount

NOTE TO ELIGIBILTY WORKER:
COMPLETE THE FOLLOWING SECTION ONLY IF APPLICABLE

You, as the recipient, are responsible for $ _____ of the following bill. After deducting this amount from the Medicaid rate or fee, the balance, if any, may be billed by your medical provider to the Medicaid program.

Bill Date	Date of Service	Patient's Name/Account Number	Amount

☐ The Managed Long Term Care plan must reduce the excess income amount collected from the Medicaid recipient by the amount shown below.

If you owe your excess income to a Managed Long Term Care plan and have provided proof of medical expenses that you have paid, the amount of the medical expenses is applied toward the amount you owe.
You have provided proof of paid medical expenses of $_____ for the month of_____. After deducting these medical expenses from your excess income of $_____, the amount you owe the Managed Long Term Care plan is $_____.

ELIGIBILITY WORKER'S SIGNATURE **X**	**TELEPHONE NO.**	**DATE**

NOTE TO AGENCY RECIPIENT AND PROVIDER:
SEE REVESE FOR IMPORTANT INFORMATION/INSTRUCTIONS.

PROVIDER, PLEASE NOTE: Since the recipient is responsible for the changes or portions thereof as indicated on the front side of this form, billing the Medicaid program for such charges to the recipient without specific authorization from the Department would be inappropriate and may constitute a fraudulent act which may result in recovery action and possible criminal prosecution.

MANAGED LONG TERM CARE PLAN, PLEASE NOTE: Since the plan is responsible for collecting the spenddown amount from the recipient, this form is sent to advise you that the recipient submitted receipts for paid medical expenses, and the amount indicated in this letter has been applied toward their monthly spenddown amount.

RECIPIENT, PLEASE NOTE: You may receive a separate form for each medical provider that you used to become eligible for Medicaid. The purpose of this form is to advise you of unpaid medical bills for which you are responsible. These are the unpaid bills which were presented to the Department to be used to help you become eligible for the Medicaid program.

A separate copy of each of the forms being sent to you is also being sent to the medical provider so that the provider will be aware of your responsibility for the bills listed on the reverse side of this form. Each provider, when more than one provider is involved, will receive a separate report containing only his/her bills. This is being done to guarantee the confidentiality of your medical services.

If you are enrolled in a Managed Long Term Care plan, pay your excess income to the plan, and you have submitted paid medical bills; this form is being sent to you to show you the amount of your excess income after deducting your paid medical bills from your excess income. Your reduced excess income amount will be collected by the Managed Long Term Care plan.

If you have any questions concerning the information on this form, please call the eligibility worker whose name and phone number appear on the front side of this form.

AGENCY, PLEASE NOTE: A separate form **MUST** be completed for each provider detailing only their bill(s); where bills from more than one provider are being used to establish eligibility.