

PROVIDER/RECIPIENT LETTER
(Provider and Recipient Responsibilities)

To: Provider (Name/Address)	To: Recipient (Name/Address)	CIN Number

This is to advise the Medicaid provider and the Medicaid recipient of the sharing of certain costs between the recipient and the Medicaid program. The Medicaid provider named on this letter must adhere to all payment exclusions/limitations as noted on this letter before billing the Medicaid program for this recipient.

Medicaid has been authorized for the above recipient for the period of _____. This authorization is for:

- Medicaid Covered Outpatient Care Only All Medicaid Covered Inpatient and Outpatient Care

This decision was based on the agency determining that the recipient has excess income and/or resources. As informed in the Notice of Decision, individuals with excess income and/or resources must incur medical expenses at least equal to the amount of the excess income and/or resources to become eligible for Medicaid coverage.

The following medical expenses are the responsibility of the recipient named above and are not to be billed to the Medicaid program by the provider.

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

The recipient is responsible for \$ _____ of the following medical expense. After the Medicaid provider deducts this amount from the Medicaid rate or fee, the Medicaid provider may bill the balance, if any, to the Medicaid program.

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

Eligibility Worker (Print)	Eligibility Worker (Signature)	Date
Supervisor (Print)	Supervisor (Signature)	Date

**PROVIDER, RECIPIENT AND AGENCY: SEE REVERSE FOR
IMPORTANT INFORMATION AND INSTRUCTIONS.**

PROVIDER, PLEASE NOTE: Since the recipient is responsible for the medical expenses or portions thereof as indicated on the front side of this letter, billing the Medicaid program for such medical expenses 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.

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

Copies of each letter sent to you are being sent to the Medicaid provider, so that the provider is aware of your responsibility for the medical expenses listed on the reverse side of this letter. When more than one provider is involved, each provider will receive a separate letter listing only the amount for the services they provided to you. This is being done to guarantee the confidentiality of your medical services.

If you live in New York City and have any questions about the information in this letter, please call the HRA Infoline at 718/557-1399.

If you live outside of New York City and have any questions about the information in this letter, please call your Local Department of Social Services. A list is available at the New York State Department of Health website at https://www.health.ny.gov/health_care/medicaid/ldss.htm.

AGENCY, PLEASE NOTE: A separate letter **MUST** be completed for each Medicaid provider detailing only the amounts of the services they provided.