

Medicare Savings Programs

Comprehensive Medicare Savings Program (MQB-Q)

- What it Covers:**
- Medicare Part A and B premiums,
 - Medicare A & B cost sharing for physicians and hospital bills
 - **It DOES NOT pay for any services not covered by Medicare, such as prescription drugs, hearing aids, eyeglasses, or dental services.**
 - You **will** get a Medicare Savings Program card.

To Qualify: See page 4 for general requirements.
Your countable yearly income cannot be over **\$10,400 per person** or **\$14,000 per couple**.

Limited Medicare Savings Program (MQB-B)

What it Covers: The yearly Medicare Part B premium ONLY. You won't get a Medicare Savings program card.

To Qualify: See page 4 for general requirements.
Your countable yearly income cannot be over **\$12,480 per person** or **\$16,800 per couple** for April 1, 2009 through March 31, 2010.

Medicare Savings Programs

Limited Medicare Savings Program (Capped Enrollment) (MQB-E)

What it Covers: The monthly Medicare Part B premium ONLY. You won't get a Medicare Savings Program card.

To Qualify: See page 4 for general requirements. This program is for people whose income is too high to qualify for the Limited Medicare Savings Program MQB-B.

Your countable yearly income cannot be over **\$14,040 per person** or **\$18,900 per couple** for April 1, 2009 through March 31, 2010.

Medicare Savings Program For Qualified Disabled Working Individuals (MWD)

What it Covers: The monthly Medicare Part A premium if you are under age 65. You won't get a Medicaid card.

To Qualify: This program is for working disabled individuals who were receiving Medicare Part A (inpatient hospital coverage) for free, but must pay the premium now because the person's earned income is higher than the limit established by the Social Security Administration. To qualify, you must:

- Be under age 65.
- Continue to meet disability requirements.
- Your countable yearly income cannot be over **\$20,800 per person** or **\$28,000 per couple** for April 1, 2009 through March 31, 2010.
- All other requirements are the same as for Medicare Savings Program (see page 4).

How to Apply

- Go to your local department of social services or call to get information on how to apply, such as applying by mail
- Give this information to your worker as soon as possible (you do not need this information to apply):
 - Your Social Security and Medicare cards or other records of your Social Security number and proof of your Medicare coverage.
 - Records of your income and your spouse's income.
 - Copies of bank statements or other documentation of checking, savings, certificates of deposit, IRAs, and any other bank account for you and your spouse.
 - Your life insurance policies, and those of your spouse or other records showing insurance company name and policy number.
 - Deeds or other records of ownership of real property for you and your spouse.
 - Copies of medical bills for you and your spouse.



If your income or assets change, you get married or divorced, your spouse dies, or you give or sell assets to someone else, you must tell your worker within 10 days. Before you transfer any kind of property, money, or other assets, talk to your worker.

You Have the Right...

- To apply, if you think you may be eligible. You cannot be denied benefits because of your race, color, national origin, sex, religion, age, or disability.
- To be notified of the information which is needed to complete your application.
- To have your application completed within 45 days, if you give the worker the information he or she needs.
- To a hearing if you are not accepted and disagree. If you do not agree with the decision made at the hearing, you can appeal to the State. If you do not agree with the State's decision, you may go to court.
- To the same quality of health care as those without Medicaid receive.
- To have your information stay confidential.

Your Medicare Savings Program Card

If you qualify for Comprehensive Medicare Savings Program MQB-Q, you will receive a card to use with your Medicare card.

When you go to the doctor's office, you must use this:

MEDICARE-AID ID CARD			
NC DEPT. OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE			
PROGRAM	ISSUANCE	VALID	
		FROM	THRU
RECIPIENT I.D.	INS. NAME CDE	BIRTH-DATE	SEX
SIGNATURE _____			

With this:

Health Insurance	
<small>SOCIAL SECURITY ACT</small>	
<small>NAME OF BENEFICIARY</small>	
<small>CLAIM NUMBER</small>	
<small>IS ENTITLED TO</small>	<small>EFFECTIVE DATE</small>
<small>SIGN HERE</small>	

SPECIMEN

To get full Medicare Savings Program coverage

You must show your Medicare Savings Program identification card (Medicare-Aid ID Card) to your doctors and at the hospital. If they tell you they accept Medicare payment for their services, they cannot bill you the difference between what they charge and what Medicaid and Medicare pay. Also, they cannot bill you if Medicaid denies payment because the doctor made a mistake on the claim form.

If You Have Medicare and Other Health Insurance

Most health insurance covers Medicare deductibles and co-insurance amounts or will pay the rest of a bill that Medicare covers. Ask your insurance company if you are not sure. If your policy is a Medicare supplement policy, call your insurance company if you are approved for the comprehensive Medicare Savings Program (MQB), and tell them to suspend your Medicare supplemental health insurance coverage. You will not be charged a premium while your coverage is suspended. You must notify your company within 90 days of eligibility.

How Medicare Savings Programs Pay for Services

1. Medicare Savings Programs automatically pay the Medicare Part B premium on your behalf.
2. The doctor's office will use your Medicare-Aid card to bill Medicaid for your medical expenses that are partially covered by Medicare.

Full Medicare Savings Program Benefits

If you need coverage for services that are not covered by a Medicare Savings Program, there are two Medicaid programs you can apply for.

- If you are over age 65, blind, **or** totally and permanently disabled, you can apply for Medicaid Health Insurance Programs for the Aged, Blind, or Disabled.
- If you are the caretaker relative of a child or children who are less than 19 years old, you should apply for Medicaid Health Insurance Programs for Families and Children.

See the booklets on these programs for more in-depth information about what they cover. If you qualify for full Medicaid benefits, you may have the option to enroll in a managed care program. Your Medicaid worker will explain the requirements and answer your questions.

Qualifying for Full Medicaid Coverage

For **regular** Medicaid coverage (not a Medicare Savings Program), people who have income over the limit to qualify for coverage can “spend down” their income. You can use old, unpaid medical expenses or current expenses to “spend down.” Then you would qualify for full Medicaid coverage. Please call your local department of social services to ask for more information.

You cannot spend down your income to become qualified for a Medicare Savings Program.

The “Spend-down” or Deductible

The “spend-down” or deductible is based on your income. The higher your income, the higher your deductible will be.

For example, suppose you are a single person with an income of \$850 a month. The income requirements for Medicaid are \$9,570 a year for an individual. To qualify for Medicaid, you will need old bills or current expenses to total \$3,348 for a 6-month period.

Estate Recovery

Estate Recovery is a claim filed against the estate of a deceased Medicaid recipient or a lien placed on property owned by the recipient when Medicaid has paid for certain medical services. The claim or lien is filed to recover Medicaid dollars paid on behalf of the individual.

Federal and State laws require the Division of Medical Assistance (DMA) to place a lien on property owned by the Medicaid recipient, or file a claim against the estate of individuals to recover the amount paid by the Medicaid program during the time the individual received assistance with certain medical services. Ask your Medicaid case worker for specific information regarding which services are applicable to estate recovery.

Lifeline/Link-up Assistance Program

The **Lifeline/Link-up Assistance Program** is for low-income individuals. The program serves recipients of the Food Assistance, Work First Family Assistance, Medicaid and Low Income Home Energy Assistance Programs, which includes the Low Income Energy Assistance Program, Crisis Intervention Program and Weatherization.

Lifeline can help pay a portion of your local telephone bill. If you are eligible, Lifeline will give you a credit each month on your local telephone bill.

Link-up is a program that can help pay to connect your telephone service.

If you are interested in applying for either one of these programs, contact your County Department of Social Services or your telephone carrier.

MEDICARE PART- D (Medicare Prescription Drug Coverage)

Definitions:

Low Income Subsidy: For individuals with income less than 150% of the federal poverty level. The LIS subsidy provides assistance with the premium payment of the prescription drug plan premium. Eligibility for this subsidy is based on income and resources. Subsidy amount may vary depending on income.

Medicare Part D: A voluntary prescription drug program through Medicare that provides all Medicare beneficiaries with prescription drug assistance. Medicare beneficiaries must also enroll in a prescription drug plan (PDP) to have prescription coverage. The Low Income Subsidy is part of the Medicare D program. Medicaid recipients that receive Medicare receive prescription drug coverage through Part D.

Prescription Drug: A drug that can only be bought with a doctor's written prescription. Medicaid does not cover drugs that are experimental. The drug must be approved by the Federal Drug Administration (FDA). Prescription drug coverage is not a covered benefit for Medicare beneficiaries. Medicaid will only cover prescription drugs for Medicare beneficiaries under certain circumstances.

Prescription Drug Plan (PDP): Prescription drug coverage that is offered under a policy, contract, or plan that has been approved by Centers for Medicare and Medicaid Services. A PDP provides insurance coverage for prescriptions.

Medicare Part D is prescription drug coverage through a Prescription Drug Plan or Medicare Advantage Plan. There is a monthly premium paid to the prescription drug plan. Under Medicare D, Medicaid recipients covered through a prescription drug plan will not have a limit on the number of prescriptions allowed per month.

All Medicare beneficiaries are entitled to Medicare Part D; however, eligible individuals must enroll in a plan to get prescription coverage. Medicaid individuals who are entitled to Medicare and choose not to enroll in Medicare D will not have prescription coverage through Medicaid.

Medicaid will only pay for prescription drugs for individuals who are not entitled to Medicare Part A or enrolled in Medicare Part B. Although Medicare Part D is voluntary, all Medicare beneficiaries receiving Medicaid services, including prescription drug coverage, must enroll in a Medicare D Prescription Drug Plan to receive prescription drug coverage.

All Medicare beneficiaries can also apply for the Low Income Subsidy (LIS). This subsidy is often called “extra help”. The subsidy provides assistance with the premium payment and a reduction in the deductible and co-pays. The subsidy may be 100%, 75%, 50% or 25% of the Part D premium depending on the individual’s income. The Low Income Subsidy is for individuals who:

- Are entitled to Part A or enrolled in Part B
- Have income less than 150% of the federal poverty level
- Have resources below \$10,000 for an individual or \$20,000 for a couple
- Apply for this extra help

Medicare recipients may apply for extra help at the Social Security Administration, at the local county departments of social services, or on the internet (on-line) at www.socialsecurity.gov. Medicaid recipients and Medicare Savings Plan recipients are automatically eligible for the LIS and do not need to apply.

For assistance in enrolling in a PDP or additional questions regarding Medicare contact: Medicare at 1(800) MEDICARE or on the internet at: www.medicare.gov, or the North Carolina Senior Health Insurance Information Program (SHIIP) at 1-800-443-9354.

If a Medicare Savings Program claim is denied...

If you receive a bill for a service that Medicare/Medicaid covers after you were told you were qualified for a Medicare Savings Program, and your doctor agreed to accept Medicaid payment, you have the right to a “reconsideration review” if Medicaid denies payment of a bill. If you want a reconsideration review, you have to ask for it no later than 60 days after the first bill.

Send the bill to:

Claims Analysis
N.C. Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

You also should write a letter and send that in with the bill. In the letter, please have:

1. The reason you are requesting the review.
2. Your Medicare Savings Program identification number.

Your review will take place within 20 days after Claims Analysis gets your letter. They will send you their decision in writing.



Frequently Asked Questions

1. How long can I receive benefits after I qualify?

You can receive benefits from Medicare Savings Programs MQB-Q, MQB-B, and MWD for as long as you continue to meet eligibility requirements. (For MQB-E, you can receive benefits from the time you qualify to December of that year, and then you can re-enroll.)

2. Can I have a Medicare Savings Program if I have private Medigap insurance?

Yes. However, you must tell your insurance company that you are receiving Medicaid within 90 days of eligibility.

3. Will Medicare Savings Programs pay for my prescriptions?

No. You must be eligible for full Medicaid coverage in order for your prescriptions to be covered. Because you receive Medicare, you must enroll in a prescription drug plan.

4. What happens if I have to go into a nursing facility?

When your Medicare no longer covers your nursing facility expenses, and you are determined eligible for Medicaid, Medicaid will take over coverage of care in a nursing facility or other medical institution. A portion of your income may have to be paid to the nursing facility each month.

The person who is in a nursing facility must meet the Medicaid nursing facility criteria in order to have Medicaid coverage for cost of care.

5. If I or an elderly parent have an income below these amounts, where can I find additional information on Medicaid?

Please refer to “A Consumer’s Guide to North Carolina Medicaid Health Insurance Programs for the Aged, Blind, and Disabled.” Call your local department of social services or the CARE-LINE Information and Referral Service at 1-800-662-7030. In the Triangle area, call 919-855-4400. Hearing-impaired callers may call either of the above numbers or the TTY dedicated line at 919-733-4851. CARE-LINE is available Monday through Friday 8 a.m. to 5 p.m. except for state holidays. A bilingual information and referral specialist is available for Spanish-speaking callers.

5. Is there someplace I can email my questions?

You can email questions regarding Medicaid to either the Division of Social Services website at dssweb@ncmail.net or the Office of Citizen Services CARE-LINE, Information and Referral Service, website at care.line@ncmail.net. Medicaid can answer your email electronically but the email is not secure. Therefore, when you email your question please indicate if you want your reply via email or U.S. Postal Service. If you want it through the U.S. Postal Service, ensure we have your mailing address.

North Carolina Medicaid
NOTICE OF
PRIVACY PRACTICES

Effective Date:
April 14, 2003
NC Division of
Medical Assistance

**THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND
DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

**YOUR PRIVACY RIGHTS, OUR
RESPONSIBILITIES**

Medicaid collects and maintains health information about you and is required by law to protect the privacy of your health information and to provide you with this Notice of Privacy Practices. This *Notice* describes how Medicaid may use and share your health information and explains your privacy rights. Medicaid will use or disclose your health information only as described in this *Notice*. We do, however, reserve the right to change our privacy practices and the terms of this *Notice* and to make new notice provisions effective for all health information that we maintain. Revised notices will be sent to you and will be available through the Medicaid contact. (See Contact Information on reverse page.) We will not change our privacy practices before you are sent a revised *Notice* unless the change is required by law.

When you were approved for Medicaid, the County Department of Social Services sent your health information to the Division of Medical Assistance so that Medicaid could pay for your health care. This information included your name, address, birth date, phone number, social security number, Medicare number (if applicable) and health insurance policy information. It may also have included information about your health condition. When your health care providers send claims to Medicaid for payment, the claims include your diagnoses and the medical treatment and supplies you received. For certain medical treatments, your health care provider must send additional medical information such as doctor's statements, x-rays or lab test results.

If at any time, you have questions or concerns about the information in this *Notice* or about our agency's privacy policies, procedures or practices; you may contact the Medicaid Privacy Official. (See Contact Information on reverse page.)

**USE AND DISCLOSURE OF PROTECTED
HEALTH INFORMATION WITHOUT
AUTHORIZATION**

There are some services Medicaid provides through contracts with other agencies such as your County department of Social Services and through private contractors that process your health care provider claims. When services are contracted, Medicaid must share enough information about you with their contractors so that they can perform the job that Medicaid has asked them to do.

To further protect your health information Medicaid will only disclose your health information after making sure in writing that its contractors will safeguard your information the same way that Medicaid does.

This agency may use or disclose your health information to provide Medicaid services to you

FOR Payment: Medicaid may use or disclose your health information to its contractors who provide payment services for Medicaid. (EXAMPLE: In order for your health care provider's claim to be paid, the contractor who processes claims for payment must have enough health information about you to verify and pay for the services you received).

Treatment: To determine if your treatment is medically necessary and is covered under Medicaid, we may use or disclose your health information to other health care professionals. These professionals have specific medical expertise so that they can give an opinion on your treatment as being medically necessary.

Health Care Operations: Medicaid may use or disclose your protected health information to perform a variety of business activities that we call "health care operations." These operations ensure that you receive quality care; the charges are appropriate for the service that you received, and that your health care providers are paid promptly. (EXAMPLE: We may contract with a private company to review the care and services our clients have received to ensure that quality care was provided.) Other "operations" that may require your protected health

information to be shared are to:

- Review and evaluate the skills, qualifications and performance of health care providers that are taking care of you.
- Provide training programs for students, trainees, professional and non-professional staff to allow them to use under supervision the skills they have learned.
- Provide information to certifying and licensing agencies so that staff may fulfill professional requirements.
- Plan our agency's future operations.
- Enhance investigations conducted by administration whenever a staff member within our agency files a grievance, or protests a particular issue.
- Provide information to other health plans and federal agencies to determine if you are enrolled as their member or covered by them.

Other Circumstances:

- Cooperate with other government agencies and outside organizations that conduct health oversight activities for the purposes allowed under federal law.
- Comply with court orders, subpoenas, administrative orders, lawsuits related to administration of Medicaid.

Contacting You:

- Contact you personally to keep you informed, such as appointment reminders, other treatment opportunities when necessary or available under certain selected public agency benefit programs.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION THAT REQUIRES YOUR AUTHORIZATION

Medicaid will not use, communicate or disclose your protected health information without your authorization except as allowed in the circumstances mentioned above. For all other uses or disclosures, we will ask you to sign a written authorization to allow us to share or request your protected health information. You may cancel such authorization by notifying our agency Privacy Official.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Medicaid clients have certain rights about their protected health care information.

YOU HAVE THE RIGHT TO:

- **Receive a copy of this Notice:** You have a right to a paper copy of this notice. You may also obtain a copy of this *Notice* by accessing Medicaid's web site at <http://www.dhhs.state.nc.us/dma> Click "Consumer".
- **Request confidential communications:** You have a right to request that Medicaid communicate with you in a certain way or at a certain location, such as calling you at work rather than at home.
- **Inspect and copy:** You have a right to request in writing to see your records and obtain a copy within 30 days at a reasonable fee. There are some exceptions to this right such as impending court actions. If this right is denied, you will be notified in writing of the reason for denial and your right to request review of the denial.
- **Request amendment:** You have a right to request in writing that portions of your Medicaid records be corrected when you feel information is incorrect or incomplete. We may deny your request if the information was not created by this agency or if we believe the information is accurate. You may then file a statement of disagreement that will be included in any future disclosures if you request it.
- **An accounting of disclosures:** You have the right to request in writing and receive a written list of certain disclosures of your protected health information made after April 14, 2003. Exceptions from this list include those disclosures regarding treatment, payment or other health care operations or disclosures allowed by certain laws, or disclosures authorized by you.
- **Request restrictions on uses and disclosures of your protected health information:** You have a right to request restrictions on the information Medicaid uses or discloses about you. Medicaid is not required to agree to your re-

requested restriction, but it will consider your request and the possibility of accommodating it.

- **Complain:** If you feel we have violated your privacy rights, you may contact either of the agencies listed below. If you file a complaint, we will not take any action against you or change our treatment of you.

COMPLAINT ADDRESSES

NC Department of Health and Human Services

Operates an information and referral service located in the Office of Citizen Services, known as **CARE-LINE**, which receives and documents complaints and concerns regarding the privacy practices, policies and procedures related to the protection of individually identifiable health information. Contact information is as follows:

CARE-LINE Email: care.line@ncmail.net

2012 Mail Service Center

Raleigh, NC 27699-2012

Voice Phone: 1-800-662-7030 (Toll Free)

(919) 855-4400 (Triangle Area)

FAX: (919) 715-8174

TTY (919) 733-4851

Secretary, US Department of Health & Human Services

You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. Contact information is as follows:

Office for Civil Rights

U.S. Department of Health & Human Services

Atlanta Federal Center, Suite 3B70

61 Forsyth Street, S.W.

Atlanta, GA 30303-8909

Voice Phone (404) 562-7886

FAX (404) 562-7881

TDD (404) 331-2867

CONTACT FOR FURTHER INFORMATION

Medicaid Privacy Official

c/o DHHS CARE-LINE Email:

care.line@ncmail.net

2012 Mail Service Center

Raleigh, NC 27699-2012

Voice Phone: 1-800-662-7030 (Toll Free)

(919) 855-4400 (Triangle Area)

FAX: (919) 715-8174

TTY (919) 733-4851

YOUR RIGHT TO APPEAL A DECISION ABOUT YOUR MEDICAID SERVICES

If you are denied medical care or services because Medicaid did not approve the care, you will receive a letter explaining the decision and telling you how you can appeal the denial.

Medicaid may also decide to reduce or stop the services you are getting. You will receive a letter before the change happens. If you appeal the decision by the deadline in the letter, your services will continue during the appeal. The letter will explain how to appeal.

HOW TO APPEAL: You have the choice of two ways to appeal if you don't agree with the decision to deny or change your Medicaid services or if a decision on your request for services is not made within a reasonable time:

1. You can ask for an **INFORMAL APPEAL** with the Division of Medical Assistance. **YOU HAVE 11 DAYS FROM THE DATE OF THE NOTICE OF DENIAL OR CHANGE TO ASK FOR THIS APPEAL.**

OR

2. You can file a **FORMAL APPEAL** with the Office of Administrative Hearings. **YOU HAVE 60 DAYS FROM THE DATE OF THE NOTICE OF DENIAL OR CHANGE TO FILE THIS APPEAL.**

IF YOU DO NOT GET A WRITTEN NOTICE:

Medicaid must make a decision promptly when your doctor or other medical provider requests Medicaid approval for services you need. If you don't get a decision within fourteen business days after when the service was requested, call your doctor or other medical provider to ask about the request. If your provider didn't cause the delay, you have the right to appeal Medicaid's failure to act on the request promptly.

Medicaid also must send you a written notice before the services paid for by Medicaid can be stopped or reduced.

If Medicaid has not sent you a notice but has not approved your request for services or has stopped or reduced your services, you can file an informal or formal appeal within a reasonable time after you requested the service and learned of your right to appeal. If services have been reduced or stopped, the services will be reinstated pending your appeal.

HOW TO ASK FOR AN INFORMAL APPEAL:

- To ask for an informal appeal, complete and return an **informal appeal** form. A sample is included at the end of this booklet (See Page 20). **Attach a copy of the notice of denial or change.** You can fax the form or mail it. See the instructions on the form.
- **DMA must receive the form no later than eleven days from the date of the notice of denial or change, unless you have good cause for delay.**
- In an informal appeal, you can have a hearing in person (in Raleigh, NC) or by telephone. A hearing officer at the Division of Medical Assistance decides informal appeals.
- You may speak for yourself, or be represented by an attorney, relative, or other spokesperson. You can ask witnesses such as your doctor to be part of the hearing or to write a letter. You will get a written decision from the hearing officer.
- If you still disagree with the hearing officer's decision, you can ask for a formal appeal after you get the decision. You will get written instructions with the decision on how to do that.

HOW TO FILE A FORMAL APPEAL:

- Formal appeals are before a judge from the Office of Administrative Hearings.
- To file a formal appeal, you must send in a contested case petition form. You can get that form by calling the DMA Hearing Office at (919) 647-8200 or 1-800-662-7030. Or you can call the Office of Administrative Hearings at 919-733-2698. You must mail the contested case petition form to **both** the Office of Administrative Hearings **AND** Legal Counsel, NC Department of Health and Human Services, 6714 Mail Service Center, Raleigh, NC 27699. **Attach a copy of the notice of denial or change.**
- **The contested case form must be filed with the Office of Administrative Hearings no later than sixty (60) days from the date of the notice of denial or change.**
- An administrative law judge will make a decision in your case. The agency then reviews that decision.
- Further appeal to court is allowed after the agency decision.
- You may represent yourself in this process, or you may hire a lawyer.
- If you ask for an informal appeal within the eleven day deadline, you can still ask for a formal appeal after your informal appeal is over. You will have 60 days after the informal appeal decision to ask for a formal appeal.

To learn more about the informal appeal process, call the DMA Hearing Office at (919) 647-8200. To learn more about the formal appeal process, call the Office of Administrative Hearings at (919) 733-2698. You may also call the toll free CARELINE at 1-800-662-7030. **Free legal aid may be available to assist with your appeal.** Contact your nearest Legal Aid or Legal Services office. Or you can call 1-877-694-2464 to find out the phone number of the Legal Aid office that serves your community.

YOUR RIGHT TO CONTINUED SERVICES PENDING AN APPEAL:

If you appeal a decision to stop or reduce your services, the service you were getting will continue during the appeal, so long as you remain otherwise eligible for that service. Medicaid will continue to pay for the services you received before the change until the end of the appeal process, unless you give up that right. If you lose a formal appeal, you may be required to pay for the services that continue because of the appeal.

FOR MORE INFORMATION about the service appeal process, visit [http:// www.dhhs.state.nc.us/dma](http://www.dhhs.state.nc.us/dma) or call CARELINE at 1-800-662-7030.

INFORMAL APPEAL REQUEST FORM

To ask for an **informal** appeal, please complete the following information and send it by mail or fax to the following address:

**Hearing Office
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX NUMBER: 919-715-6394**

If you can, include a copy of the notice you want to appeal. But keep a copy of that notice.
We must receive this form no later than ELEVEN (11) days from date of the attached notice.

[Insert name of Medicaid recipient]
[Insert address of Medicaid recipient]
[Insert MID number]

I would like to appeal the denial of [Insert Service being denied/reduced].

Check which type of hearing you want:

In-person hearing in Raleigh, North Carolina.

Telephone hearing, using the telephone number listed below.

Signature of Medicaid Recipient or Responsible Party

Date

Relationship to recipient: _____

Phone Number (with area code): () _____

Address (if different than above): _____

Fill out the next section if you have a lawyer or other representative to assist you in this appeal:

I authorize the following person to represent the above recipient. Upon request, I authorize you to release any and all medical records and other documents and confidential information which may pertain to the hearing.

Name of Representative: _____

Address: _____

Phone: () _____

Signature of Medicaid Recipient or Responsible Party

Date

To ask for a formal appeal, do NOT use this form. Follow the instructions on the attached notice. You have **SIXTY DAYS** from the date of the attached notice to ask for a **formal** appeal. If you have questions, you may call the toll-free CARELINE at 1-800-662-7030. Ask for the DMA Hearing Office.