

**TO ALL DISTRICT OF COLUMBIA MEDICAID RESIDENTS WHO PAID FOR
MEDICAL EXPENSES THAT SHOULD HAVE BEEN PAID BY MEDICAID**

If you do not speak and/or read English, please call toll-free 1-877-685-6391 between 8:15 a.m. and 4:45 p.m. and a representative will assist you.

Si usted no habla ni/o no lee Inglés, por favor llame gratis al 1-877-685-6391 entre las 8:15 a.m. y 4:45 p.m. y un representante lo ayudará.

አባታችን በጥንቃቄ ያንቡት፤
ይህ ደብዳቤ ስኬት እንከብካቤዎ አገልግሎት ከውጦች ይመክታል።
እንግሊዝኛ የሚያናገሩ እና/ወይም የሚያነቡ ከሆኑ፤ አባታችን በነፃው የሰነድ መሰመር በ 1-877-685-6391 ከጥዋቱ 8:15 እስከ ከሰዓት በሁዋካ 4:45 መካከል ባከው ጊዜ ውስጥ ይደውሉና ተወካዮችን ይርዱ።

如果您不會說和/或無法閱讀英文，請於早上 8:15 至下午 4:45 之間撥打免費電話 1-877-685-6391，將會有代表為您提供幫助。

Si vous ne parlez et/ou ne lisez pas l'anglais, veuillez appeler le numéro gratuit 1-877-685-6391 entre 8h15 du matin et 16h45 et un représentant vous assistera.

영어가 불편하시면 수화자 무료 전화번호인 1-877-685-6391 로 아침 8 시 15 분부터 오후 4 시 45 분 사이에 전화해 주세요. 고객 서비스 담당직원이 도와드리겠습니다.

Nếu quý vị không nói và/hoặc đọc được Tiếng Anh, xin hãy gọi đến số điện thoại miễn phí 1-877-685-6391 từ 8:15 sáng đến 4:45 chiều, và một nhân viên đại diện sẽ trợ giúp quý vị.

If you paid for drug prescriptions, doctor visits, or hospitalizations during a time that you were eligible for Medicaid, you may be able to be reimbursed for the expenses.

REQUIREMENTS: You may be eligible for reimbursement if during a period of time you or a family member were eligible for Medicaid, if:

- a. You paid for drug prescriptions, doctor visits, or hospitalizations; or
- b. You are still paying a bill or are being asked to pay a bill by a pharmacy, clinic, doctor, or hospital for drug prescriptions, doctor visits, or hospitalizations.

If you believe that you are entitled to reimbursement, you must request reimbursement within six (6) months of the date you went to the pharmacy, clinic, doctor, or hospital, or within six (6) months of the date you learned you were eligible for Medicaid.

DEFINITION OF “ELIGIBLE FOR MEDICAID”: The period of time for which you are “eligible for Medicaid” and may be eligible for reimbursement means:

1. The dates that the District of Columbia stated you (and/or your family members) were eligible for Medicaid.
2. The three (3) months before you submitted your application for Medicaid (and you were later found eligible).
3. The time after you filed your application for Medicaid and were waiting for a decision (and you were later found eligible).
4. Any time you were improperly denied eligibility of services:
 - a. If the District of Columbia improperly stopped your eligibility at the time of recertification.
 - b. If the pharmacy, clinic, hospital, or doctor’s office required you to pay because they said you were not on Medicaid when you actually were.

IN ORDER TO BE REIMBURSED, YOU MUST:

1. Complete the enclosed Medicaid Reimbursement Form.
2. Attach the receipt from the doctor, clinic, hospital or pharmacy that shows the expenses you paid.
3. If you do not have a receipt from the doctor, clinic, hospital or pharmacy, you may provide a signed and dated letter explaining why you do not have the receipt.
4. Submit the Medicaid Reimbursement Form with the receipt(s) (or the letter explaining why you do not have a receipt) to the address on the Medicaid Reimbursement Form.
5. **Remember** that you have six (6) months from the date you went to the pharmacy, clinic, doctor, or hospital or from the date you learned you were eligible for Medicaid to pay the expense, to submit the Medicaid Reimbursement Form. If you do not have all of the information, you should submit as much information as you have available.
6. Reimbursement will only be made for expenses that should have been paid by Medicaid. You should carefully review the documents you submit to be sure that they are fully accurate.

IF YOU HAVE QUESTIONS OR IF YOU NEED HELP COMPLETING THE FORM OR OBTAINING REQUESTED INFORMATION CONTACT:

- a. The Medicaid Recipient Claims Research Team of the D.C. Department of Health Care Finance (DHCF) at (202) 698-2009.
- b. Terris Pravlik & Millian, LLP, 1121 12th Street, NW, Washington, DC 20005, (202) 682-0578, who will provide you with free legal assistance.

A DECISION ON YOUR REIMBURSEMENT CLAIM MUST BE MADE WITHIN 90 DAYS:

- a. The Medicaid Recipient Claims Research Team must make a decision on your reimbursement claim within 90 days from the time you file your claim. If no decision is made within those 90 days, your claim will be treated as valid, and you will be paid within 15 days after the end of the 90 day period.
- b. If you are not satisfied with the decision of the Medicaid Recipient Claims Research team, you have a right to a fair hearing. You may request a fair hearing by calling the Office of Administrative Hearings at (202) 442-9094. The Office of Administrative Hearings is located at 441 4th Street, NW; Washington, DC 20001-2714.
- c. If you are not satisfied with the result of the fair hearing, you may appeal to the United States District Court of the District of Columbia within 30 days. You may obtain free legal assistance to help you present your case at the fair hearing or at the appeal by contacting Terris Pravlik & Millian, LLP at 1121 12th Street, NW; Washington, DC 20005 or (202) 682-0578.

MEDICAID REIMBURSEMENT REQUEST FORM

Today's date

DIRECTIONS: Complete and return, with receipts, within 6 months after you went to the clinic, doctor, hospital, or pharmacy – or 6 months of the date you learned you were eligible for Medicaid -- to:

Recipients Claims Research Team
 DC Department of Health Care Finance
 441 4th Street NW – 900 South
 Washington, DC 20001

Please give as much information as you can. Attach copies of your receipts. If you don't have a receipt, attach a signed and dated letter that explains why you don't have it. If you're asking for reimbursement of expenses from more than 1 provider (like a doctor *and* a pharmacy), please use separate lines for each.

Your Name	Mailing address	Your phone numbers		
Social Security Number of Medicaid Recipient		Day		
		Evening		
Birth Date of Medicaid Recipient	Name & Medicaid ID # of Recipient Requesting Reimbursement			
		Cell		

SUMMARY OF INFORMATION ON ATTACHMENTS

For each expense (drug prescription, doctor visit or hospitalization), give this information*

Date (or estimated date) of expense	Name and address of pharmacy, clinic, doctor or hospital	How much you paid	How much you still owe	How much any other insurance paid	How much you want Medicaid to reimburse

*Attach a copies of any letters or bills from the pharmacy, clinic, doctor or hospital; or letters from credit collection companies about the bill.

I swear and declare, under penalty of perjury, that the statements I made on this paper and on any attached papers are true and correct.

Signature