COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS
BUREAU OF PROGRAM INTEGRITY
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675
(717) 772-4627
1 866 400-5843
www.dpw.state.pa.us/omap

Mail Date

Dear (Recipient Name): Case Number:
Individual Number:

A review of medical services paid under your case number by the Department of Public Welfare (Department), shows that you have misused your Medical Assistance ACCESS card.

You visited ___ doctors and ___ pharmacies from _____ to _____and:

___ Received the same/similar services from different doctors/pharmacies
___ Received the same/similar medications from different doctors/pharmacies
___ Received the same/similar controlled drugs from different doctors/pharmacies
___ Received early refills/fills of prescriptions
___ Had ___ Emergency Room visits at ___ hospitals from _____ through _____
___ Had __ inpatient admission at __ different hospitals from _____ to _____
___ Other:

This is to notify you that according to the enclosed regulations 42 CFR Ch. IV §431.54(e), 55 Pa. Code §1101.91 and §1101.92 and (c)(2) you are being placed in the Recipient Restriction Program. You must use the following provider(s) for all your routine medical, and pharmacy services for a period of 5 years beginning _____ to manage your health care.

Primary Care Doctor	Pharmacy

You must use your ACCESS card to obtain services from only your designated provider(s). This restriction does not apply to a medical emergency. You may obtain emergency medical care from any participating Medical Assistance provider.

The restriction will not stop you from going to a specialist. If your primary care doctor has referred you for specialized care, he/she will give you a Restricted Recipient Referral form (MA 45).

If you want to change your doctor/pharmacy before the restriction begins, write their name and address on page 3. Return it within 10 days in the enclosed envelope. You may change your provider(s) at any time by giving a 30 day written notice to the Bureau of Program Integrity.

This restriction remains in effect whether you receive services with the ACCESS card or a Managed Care Organization (MCO).

You may appeal the Department's proposed restriction by sending your written request for a hearing in the enclosed envelope. Please put your phone number on your appeal letter. Your appeal must be received within 30 days from the date of this letter and should be mailed to the following address:

Bureau of Program Integrity
Recipient Restriction Section
P.O. Box 2675
Harrisburg, PA 17105-2675

If your appeal is received within 10 days from the date of this letter, the restriction will not go into effect, pending the decision from the hearing. If your appeal is received more than 10 days, but less than 31 days from the date of this letter, the restriction will go into effect.

The Bureau of Hearings and Appeals will notify you in writing of the date, time, and location of the hearing.

If you wish to discuss this proposed restriction, please call the Recipient Restriction Section at 1-866-400-5843 or (717) 772-4627.

Sincerely,

Division of Program and Provider Compliance

Enclosure

DEPARTMENT OF PUBLIC WELFARE

Choice of Doctor

Name:
Address:

Phone:

RECIPIENT'S

Choice of Doctor

Name:
Address:

Phone:

DEPARTMENT OF PUBLIC WELFARE

Choice of Pharmacy

Name:
Address:

Phone:

RECIPIENT'S

Choice of Pharmacy

Name:
Address:

Phone:

Recipient's or Head of Household's
Signature:
_____

Date: _____

Phone: _____