CORRECTIVE ACTION PAID MEDICAL EXPENSE REPORTING FORM

CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CTR DIG	DIST

DATE

You have been found eligible for Medical Assistance Corrective Action benefits for the period _____ 20____, to _____ 20____.

If you received and paid for medical services in this period you MAY be eligible for reimbursement of your paid bills.

***PAYMENT MUST HAVE BEEN MADE BY YOU OR A PERSON LEGALLY RESPONSIBLE FOR YOUR BILLS.**

Check your bill to make certain that you received and paid for the service in the time period shown above. Only those expenses can be considered.

Contact the medical provider who provided the service (doctor, pharmacist, hospital) and ask if the medical provider is enrolled in the MEDICAL ASSISTANCE PROGRAM, or was enrolled at the time the medical service was given. IF THE PROVIDER IS NOT, OR WAS NOT, ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM, YOU ARE RESPONSIBLE FOR PAYMENT OF THE BILL. **PLEASE DO NOT SUBMIT THIS FORM.**

MA ENROLLED PROVIDER

If the provider is, or was, enrolled in the Medical Assistance Program at the time the service was received:

- Fill out the remainder of this form within 30 calendar days of receipt from the county assistance office
- Please provide all the requested information on this form or it will be returned to you for completion.
- Attach a copy of the bill (or bills) **AND** proof of payment, and

MAIL TO: BFFSP/Division of Operations
ATTENTION: CLIENT REIMBURSEMENT
P.O. Box 8046
Harrisburg, Pennsylvania 17105

You will be notified by the Bureau of Fee For Service Programs (BFFSP)/Divison of Operations if you are entitled to a reimbursement.

MEDICAL SERVICES RECEIVED AND PAID:		
PROVIDER NAME:	DATE OF SERVICE:	DATE(S) OF PAYMENT:
PROVIDER NAME:	DATE OF SERVICE:	DATE(S) OF PAYMENT:

☐ I have NOT been, nor do I expect to be, reimbursed - fully or in part - for any expenses listed by any other source.

YOUR SIGNATURE:	PRINT YOUR NAME:	
TELEPHONE PHONE NUMBER, INCLUDE AREA CODE (PHONE NUMBER WHERE YOU CAN BE REACHED): ( )		DATE:
LEGALLY RESPONSIBLE PERSON'S SIGNATURE:		
PRINT NAME:	TELEPHONE NUMBER: ( )	DATE:

NOTE: 1. CHECK FORM BEFORE MAILING. 2. REMEMBER TO ATTACH A COPY OF YOUR BILL AND PROOF OF PAYMENT.

INSTRUCTIONS FOR CORRECTIVE ACTION PAYMENT/REIMBURSEMENT OF PAID AND UNPAID MEDICAL EXPENSES

The attached Corrective Action Medical Expense Reporting Form provides your eligible corrective action coverage period for paid and unpaid medical services.

PAID BILLS

A paid medical expense must have been paid by you or a person legally responsible for you.

If you have a paid bill for medical service received in the corrective action coverage period, contact the medical provider to find out if the provider is currently enrolled in the MA Program or was enrolled at the time you received the service.

- If the medical provider is not, or was not, enrolled in the MA Program, you are responsible for the payment.
- If the medical provider is, or was, enrolled in the MA Program, please read carefully and complete the attached "CORRECTIVE ACTION PAID MEDICAL EXPENSE REPORTING FORM." Mail the form and required documentation to:

  BFFSP/Division of Operations
  ATTENTION: CLIENT REIMBURSEMENT
  P.O. Box 8046
  Harrisburg, Pennsylvania 17105

QUESTIONS

If you have questions after the BFFSP/Division of Operations notifies you in writing of the decision about your paid medical expenses, please contact the Office of Medical Assistance Programs Recipient Service Center at 1-800-537-8862, opt. 2, 3.

If you have questions regarding this form, the instructions or unpaid bills, please contact Recipient Service Center at 1-800-537-8862, opt. 2, 3.

RIGHT TO APPEAL AND FAIR HEARING

If you disagree with the county assistance office decision or the BFFSP/Division of Operations decisions, you have the right to appeal and receive a fair hearing. Please contact your county assistance office and/or local legal services agency to file your appeal.