

Erroneous Authorization Dates of Medicaid Eligibility

TO: _____, Supervisor
DMA Claims Analysis Unit

FROM: _____, Medicaid Supervisor

County DSS

DATE: _____

RE: Recipient Name: _____

Recipient MID: _____

Erroneous Date(s): _____

Correct Date(s) From and To: _____

The following providers were contacted and notified of the erroneous eligibility authorization and requested not to bill Medicaid for services provided during the ineligible date(s) or to the ineligible individual:

Provider Name(s) and Address(es)	Date Contacted
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