

Fee Schedule Request Form

There is no charge for fee schedules requested from the Division of Medical Assistance (DMA). DMA **Providers are expected to bill their usual and customary rate.** Please note that fee schedules change regularly and you will be provided with the most current version upon receipt of your request.

If you are not able to download a fee schedule from the website, please use this document to request a fee schedule.

Requests for fee schedules can be **mailed** to:

Division of Medical Assistance
Financial Management/Rate Setting - Fee Schedules
2501 Mail Service Center
Raleigh, N. C. 27699-2501

Or **fax** your request to DMA's Financial Management/Rate Setting section at **(919) 814-0037**.

Or **E-mail** your request to Muriel.Dean@dhhs.nc.gov

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|--|--|
| <input type="checkbox"/> Adult Care Homes Personal Care Services | <input type="checkbox"/> Independent Practitioner |
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> Ambulatory Surgical Centers | <input type="checkbox"/> Local Educational Agencies |
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Medicaid Crossover Percentage Payment |
| <input type="checkbox"/> Auditory implant parts | <input type="checkbox"/> Nurse Midwife |
| <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Nurse Practitioner and CRNA |
| <input type="checkbox"/> Community Alternatives Program (CAP) | <input type="checkbox"/> Nursing Facility Rates |
| <input type="checkbox"/> Chiropractic Services | <input type="checkbox"/> Optical Program |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Optometry Services |
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Federally Qualified Health Center | <input type="checkbox"/> Physician Drug Program |
| <input type="checkbox"/> Freestanding Birth Center Services | <input type="checkbox"/> Physician Services |
| <input type="checkbox"/> Hearing Aid Program | <input type="checkbox"/> Podiatry Services |
| <input type="checkbox"/> HIV Case Management | <input type="checkbox"/> Radiological/Imaging Services |
| <input type="checkbox"/> Home Care | <input type="checkbox"/> Rural Health Clinic |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Targeted Case Management |
| <input type="checkbox"/> Home Infusion Therapy | <input type="checkbox"/> Vent Facility Rates |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> Hospitals | |
| <input type="checkbox"/> ICF-MR | |

Name (Provider/Facility): _____

Provider Type: _____ Provider #: _____

E-Mail Address _____

Contact Person: _____ Phone #: _____

The requested fee schedule will be e-mailed in of the following formats: **Excel** or **Adobe PDF**