Print Form

CAP/DA BILLING CLAIM DENIAL TECHNICAL ASSISTANCE REQUEST

Contact Person:	**Lead Agency Name**:
Beneficiary Name:	**MID #**:
Procedure Code billed:	**Units Billed**:
TCN #:	

Date(s) Of Service	From: _____/_____/_____ To: _____/_____/_____	**Billed Amount**: $_____ **Denied Amount**: $_____
Place of Service:		

Program:

☐ CAP DA ☐ CAP Choice ☐ CAP DA/MFP ☐ CAP Choice/MFP

FL-2 Prior Approval Date:	/ /
CAP Effective Date:	/ /
Reason for Denial:	
Last Date Billed:	/ /
What steps were attempted to reconcile claim denials? Briefly Explain and attach supporting documentation.	

Signature:	**Date**: / /	**Contact Email:**

DMA INTERNAL USE ONLY

Billing Claims Findings

☐ The wrong procedure code was billed.
☐ The wrong # of units/frequency/duration was billed.
☐ The FL-2 was denied prior approval.
☐ The beneficiary is in an institution.
☐ The CAP indicator code is not in EIS.
☐ The wrong CAP indicator code is in EIS
☐ The beneficiary is deceased.
☐ The beneficiary's Medicaid is under a sanction, terminated or in deductible status.
☐ The beneficiary is receiving another duplicative service.
☐ The provider is not enrolled to render the service.
☐ Other. _____

Actions Steps to reconcile denied claims:

Reviewed by:	**Date reviewed**: