

NOTICE OF CHANGE IN OVERPAYMENT FOR MEDICAL ASSISTANCE

Date: _____

Name: _____ Program Code: _____
Address: _____ EIS Case ID: _____
_____ SSN: _____
_____ County Case ID: _____

Dear _____:

You were notified on _____ that you are responsible for a medical assistance overpayment because you and/or members of your household for whom you are financially responsible received Medicaid or NC Health Choice benefits that you were ineligible to receive. The original "Notice of Overpayment for Medical Assistance" informed you that the amount of your overpayment would increase if additional medical expenses were paid for the period of ineligibility.

We have reviewed the medical expenses paid during the period of ineligibility and your total overpayment is \$ _____. The amount you currently owe on this debt will be reduced by all payments that have been made. You can contact me at the number below to verify the amount you currently owe on this debt.

You must make every effort to repay the full amount owed. If you have not previously signed a voluntary repayment agreement, contact me at the number below to make arrangements to establish a repayment schedule in order to prevent further collection action. If you have questions about your current repayment agreement, contact me to schedule an appointment to review your current repayment agreement.

Sincerely,

Program Integrity Investigator
_____ County Dept. of Social Services
(_____)_____

cc: file copy

Si necesita ayuda para entender esta carta de notificación de un pago excesivo por asistencia médica, comuníquese con la unidad de integridad de este programa en el departamento de servicios sociales del condado indicado arriba.