

MEDICAID/NC HEALTH CHOICE RECIPIENT PROFILE REQUEST SHEET

CONFIDENTIAL

Return Profiles to:

Worker Name: _____

Title: _____

County: (____) _____

Initial Profile Request Date: _____

Follow-up Profile Request Date: _____

Case Head: _____

EIS Case ID #: _____

EPICS Referral ID #: _____

Is the period of ineligibility due to a transfer of assets sanction? NO YES **If yes:** LTC PLA CAP

Is this request for Family Planning Waiver profiles? NO YES **If yes, please check FPW box next to the Thru date.**

Recipient Name (First, MI, Last)	Individual MID #	(Dates of Service)		Program/Class
		From - MM/DD/CCYY	Thru - MM/DD/CCYY	
			FPW <input type="checkbox"/>	
			FPW <input type="checkbox"/>	

Recipient Name (First, MI, Last)	Individual MID #	(Dates of Service)		Program/Class
		From - MM/DD/CCYY	Thru - MM/DD/CCYY	
			FPW <input type="checkbox"/>	
			FPW <input type="checkbox"/>	

Recipient Name (First, MI, Last)	Individual MID #	(Dates of Service)		Program/Class
		From - MM/DD/CCYY	Thru - MM/DD/CCYY	

Recipient Name (First, MI, Last)	Individual MID #	(Dates of Service)		Program/Class
		From - MM/DD/CCYY	Thru - MM/DD/CCYY	

Recipient Name (First, MI, Last)	Individual MID #	(Dates of Service)		Program/Class
		From - MM/DD/CCYY	Thru - MM/DD/CCYY	

Instructions for DMA-7063 – Medicaid/NC Healthchoice Recipient Profile Request Sheet

1. Fill in the name and title of the worker requesting profiles.
2. Fill in county number and name.
3. Fill in the date of the initial profile request unless this is a follow-up request.
4. Fill in the follow-up profile request date unless this is the initial request.
5. Enter the Case Head Name.
6. Enter the EIS Case ID number.
7. Enter the EPICS Referral ID #.
8. Indicate whether the period(s) of ineligibility is due to a transfer of assets sanction and, if yes, check the recipient's living arrangement during the sanction period. Living arrangement determines which claims are considered non-covered during a transfer of assets sanction.
9. Indicate whether this request is for FPW claims. If "YES", check "FPW" by through date. Note: FPW program began 10/01/05.
10. For each ineligible recipient fill in the information as follows in the spaces provided:
 - Recipient Name
 - Recipient's Individual Medicaid ID number.
 - From and Through Dates for each Overpayment Period for which Medicaid Profiles are requested. Use MM/DD/CCYY format. If all ineligible periods are consecutive use one line. If there is a break in overpayment periods put each separate period on a separate line.
 - The Medicaid program and classification for each overpayment period requested.
11. Continue to fill out the information required for each ineligible recipient for that EIS Case ID. Continue on a second DMA-7063 if needed.
12. **Do not combine Medicaid and NC Health Choice requests on the same sheet. Note: NCHC claims are available beginning 7/01/2010.**
13. Mail or fax the completed DMA-7063, Medicaid Recipient Profile Request Sheet to:

**Division of Medical Assistance
Quality Assurance Section - 18
2501 Mail Service Center
Raleigh, NC 27699-2501**

Fax: 919-715-7706

Note: Allow three weeks for processing and delivery. If profiles are not received within three weeks of the original request date, **please do not send a 2nd request until you verify whether DMA received your original DMA-7063 to avoid the expense to DMA of ordering, processing and mailing duplicate profiles.** Call DMA at 919-647-8000 to check on the status of your original request. Once you verify DMA never received your original request, re-fax or mail a copy of the original DMA-7063 and write **2nd Request** in bold on the form.

Contact your Recipient Investigations Coordinator at 919-647-8000 if you have questions regarding how to interpret the Medicaid Profiles or have questions about how to determine the amount of the overpayment.