

SPECIAL OVERRIDE REQUEST FOR PREVIOUSLY DENIED MPW APPLICATIONS

MEMORANDUM

To: Division of Medical Assistance
Claims Analysis Unit

From: _____ Telephone Number: _____
_____ County Department of Social Services

Date: _____

Re: Request for Claims Override

COMPLETE ALL PERTINENT SECTIONS

Recipient: _____ MID: _____

Date of Application: _____ Date of Disposition: _____

This override is requested because the MPW application was reopened and approved according to policy in DMA Administrative Letter No. 03-04 regarding review of MPW applications denied due to application of parental financial responsibility.

Eligible dates in EIS for which override is needed: _____

Send notice of override approval to: Recipient Responsible person

Responsible person: Name _____

Address _____

To: _____ Department of Social Services

From: Claims Analysis Unit
Division of Medical Assistance

Recipient: _____ MID: _____

OVERRIDE APPROVAL

Override authorization is **approved** for this recipient for the following date(s):

Advise the recipient to inform all medical providers to file outstanding claims directly with EDS, the Medicaid contractor, no later than _____

If the recipient is deceased or otherwise unable to notify providers, the IMC must follow procedures in MA-2395/MA-3530, III.D.7.b

OVERRIDE DENIAL

The override request is **denied** for all or part of the date(s) because:

Failure of the provider to file timely is not a basis for override.

The claims filing time limit has not expired. No override is needed.

Other: _____

Date

Claims Analyst, DMA