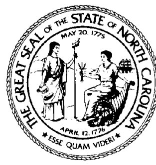

North Carolina Department of Health and Human Services
Division of Medical Assistance
2501 Mail Service Center • Raleigh, N. C. 27699-2501 • Tel 919-855-4100 • Fax 919-733-6608

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary

Craigan L. Gray, MD, MBA, JD, Director

May 10, 2012

Subject: Alien Emergency Service Reviews

Dear County Director of Social Services:

This letter serves as a reminder to the County Department of Social Services of the procedures regarding Alien Reviews for Emergency Services. Effective October 1, 2011, Maximus became the new contractor for alien reviews for Emergency Services. All reviews must be sent to Maximus via fax, mail or CD/DVD. Alien review packets are not sent to CCME, the former contractor for alien reviews. Reviews sent to CCME will be returned to the local county DSS resulting in a delay in processing time.

All packets must be accompanied by a **completed** DMA-5135, Date(s) of Emergency Services Requests for an Alien. Attached is an instructional version of the DMA-5135. Please ensure that all pertinent medical evidence for dates requested are included in the review packet. The name of the applicant/recipient must match the name on the medical evidence provided. Refer to MA-2504/3330, Alien Requirements, for complete procedures.

If you have any questions regarding this information, please contact your Medicaid Program Representative.

Sincerely,

Craigan L Gray, MD, MBA, JD, Director

CLG/el
Attachment

* indicates required information

DATE (S) OF EMERGENCY SERVICES REQUESTED FOR AN ALIEN

TO: **Maximus***____

FROM: **County Name***___________________County Department of Social Services

RE: Emergency Services for an Alien

Date: **Request date (The date the form is completed)***____________

Applicant's Name: **Must match medical records or provide explanation** *Aid Program/Category: **acronym***

MID **9 numbers 1 letter*** Sex: **required*** DOB: **Must match record or provide explanation***

Application Due Date (45th/90th Day): ____

The individual named above has applied for Medicaid payment for emergency care as defined in Alien Requirements, MA-2504/3330, of the Medicaid Eligibility Manual. The following dates of service are requested, and I certify that I am enclosing appropriate medical records to cover each date requested:

Date of service (DOS) must be specific, including month, days, year. Every date claimed must be supported by existing medical records provided to Maximus, future DOS may not be claimed*

____ ____

____ ____

NOTE: Determination of eligibility cannot be made without the required medical records for the dates of service requested. Do not send medical records for dates other than those indicated.

County Contact Person: **Required information***____

E-Mail Address:____

Telephone No. **Required information***____________ Fax No.: **Required information***_______

****
Emergency services approved. To be completed by the medical review staff.

Dates: ___/___/___ through ___/___/___ Dates___/___/___through___/___/___

Dates: ___/___/___ through ___/___/___ Dates___/___/___through___/___/___

Comments:____

____

____

____

Signature of Reviewer Date

Revised 05/2011
DMA-5135