North Carolina Department of Health and Human Services
Division of Medical Assistance

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Sandra Terrell, MS, RN
Acting Director

October 11, 2013

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. Maximus has reported that recent reviews have excessive errors involving missing names, contact information, and necessary information needed to complete the review. It is important that the name of the applicant/beneficiary match the name on the medical evidence provided. Incomplete and inaccurate reviews sent to Maximus will be returned to the local county DSS resulting in a delay of processing time.

Please ensure that all pertinent medical evidence for dates requested is included in the review packet. All review packets must be accompanied by a completed DMA-5135. Review packets must be sent to Maximus via fax, mail or an encrypted CD/DVD. Attached is an instructional version of the DMA-5135. 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,

Sandra Terrell, MS. RN
Acting Director

www.ncdhhs.gov • www.ncdhhs.gov/dma
Tel 919-855-4100 • Fax 919-733-6608
Location: 1985 Umstead Drive • Dorothea Dix Hospital Campus • Raleigh, NC 27603
Mailing Address: 2501 Mail Service Center • Raleigh, NC 27699-2501
An Equal Opportunity / Affirmative Action Employer

* 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***

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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