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

November 13, 2009

Re: NC Free Clinic Verification Form

Dear County Directors of Social Services:

The purpose of this letter is to notify counties of a form that has been created by North Carolina Association of Free Clinics to use when verifying Medicaid eligibility for recipients. NC Free Clinics provide medical/dental services to uninsured and underinsured patients; however because they are not a Medicaid provider, they do not have a means of verifying patient eligibility. Therefore, they have created the attached form to be completed by local department of social service agencies to verify Medicaid eligibility. When you receive one of these forms, please complete and fax it to the NC Free Clinic as soon as possible. A copy of the verification letter is attached.

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

Sincerely,

Craigan L Gray, MD, MBA, JD, Director

Attachment

NC Free Clinic NAME
Address
City
Phone & Fax #'s

NC DEPT. OF SOCIAL SERVICES
MEDICAID PROGRAM VERIFICATION REQUEST

_____
Applicant's Name

DOB _____ SSN _____
(If available)

Address _____

_____

The above named applicant has applied for health care services from (*NC Free Clinic Name).* As a free clinic we provide medical/dental services to uninsured and underinsured patients. The above applicant has presented with a Medicaid ID card and states he/she is eligible only for the Medicaid Family Planning Waiver Benefit Program &/or that his/her full Medicaid eligibility has been terminated.

As *(NC Free Clinic Name)* is not a Medicaid provider and has no access for verifying Medicaid recipient's eligibility and benefits, we request your assistance so we may assess this applicant's eligibility for receiving health care services from our organization.

I authorize _____ County Department of Social Services to confirm/verify my current Medicaid eligibility/benefit status.

_____ _____
Medicaid Recipient's Signature Today's Date

☐ I **confirm/verify the above named recipient is currently only eligible for medical services rendered through the Medicaid Family Planning Waiver Program.**

☐ **I confirm/verify that the above named recipient's current eligibility is for full Medicaid.**

☐ **I confirm/verify that the above named individual is currently not eligible for Medicaid, terminated effective _____ (date).**

_____ _____
DSS Staff/ Case Worker Signature Today's Date

PLEASE FAX COMPLETED REQUESTION TO ( ) _____