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
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