(Provider completes)

North Carolina Division of Medical Assistance
Notice of Case Status

Enter Name and Address of County DSS

_____

_____

_____

NOTE: DO NOT make this referral without the knowledge or consent of the patient and/or his family.

Please determine whether the patient is eligible for medical assistance under Title XIX Medicaid. Use the reverse side to notify us of your decision.

1. Patient's Name (First, Mi, Last)		2. Telephone number
3. Address		
4. Date of Birth	5. Social Security Number	6. Sex ☐ Female ☐ Male
7. Spouse's Name		
8. Parent's/Guardian's Name (Give only if patient is a minor child)		
9. Inpatient Hospital Admission Date: _____Month _____ Day 20_____Year		
10. Estimated Discharge Date: _____Month _____ Day 20 _____Year		
11. Daily Charges-to-Date: _____Attached _____ Will be provided upon discharge.		
_____ Name of person completing form	_____ Date	_____ Title
Provider's Name and Address		Telephone Number
Consent of Patient/Parent/Guardian to referral		
_____ Signature	_____ Date	_____ Relationship to Patient

Instructions

1. Provider:
   a. Do not make this referral without the knowledge or consent of the patient and/or his family.
   b. Prepare original and one copy. Send original to the county DSS and retain the copy for your files.
2. County:

   See reverse side of this form for detailed instructions.

DMA-5020
Revised 01-04

(County completes)

North Carolina Division of Medical Assistance
Notice of Case Status
_____County Department of Social Services

Enter name and Address of Provider

_____

_____

_____

1. Name: (First, MI, Last)		
2. Individual ID Number	3. Aid Program/Category	4. Classification Code
5. This response acknowledges receipt of your referral and informs you of the status:		
a. ☐ Medicaid authorization begins on:		Patient payment due hospital: $
b. ☐ An application has been filed and is being processed. You will be notified when the decision is made.		
c. ☐ We are waiting for the applicant/recipient to return necessary information to make a determination of eligibility.		
d. ☐ Medical information required to establish incapacity has not been returned from the patient's doctor. Form DMA-5006 is attached for completion. Please return to this office when completed.		
e. ☐ The individual was notified on _____to come to the agency to file an application for Medicaid.		
f. ☐ Patient is not eligible for Medicaid.		
6. Carolina ACCESS ☐ Yes ☐ No Primary Care Provider is_____ (Name)		
County Director Signature /Designee		Date

Instructions: County Department of Social Services

A. Within 15 workdays after receipt, complete status information. Return original to the provider and retain a copy for your file.

   1. If the patient is eligible, enter the Medicaid ID number in block 2.

   2. If the individual is eligible for dates of hospitalization, check block 5.a. and enter authorization from date.

   3. If the case has a deductible, enter in block 5.a., the amount of the deductible balance applied to the hospital charges on date of authorization. This amount must agree with the deductible balance amount entered in EIS.

B. If block 5. b. c. d. or e. is checked, you must notify the provider of the final disposition. Note the final disposition on the file copy and send a copy to the provider.

C. Use this form to notify the hospital of the deductible amount due the hospital for any hospitalized recipient whether or not hospital has initiated referral.