Request for Claims Override

To: Division of Health Benefits
DSS Support Unit

From:_____ County:_____
(Income Maintenance Caseworker) (Department of Social Services)

Phone number:_____ Email:_____

Date: _____

COMPLETE ALL PERTINENT SECTIONS

Beneficiary:_____ MID:_____

Date of Application:_____ Date of Disposition:_____

Reason for override request – **MUST SELECT ONE**: **(There are NO other acceptable reasons.)**

☐ Social Security/SSI disability approval after a Medicaid disability denial:

☐ SSA/SSI disability denial subsequently reversed by SSA.
Onset of disability:_____

Date notice of approval received by DSS:_____

Authorization limited to the later of the date of application or onset of disability.

☐ Medicaid disability denial subsequently approved by SSA.
Onset of disability:_____

Date DSS learned of SSA/SSI approval:_____

Authorization limited to 12 months prior to the county's learning of SSA/SSI approval.

☐ County/State hearing decision in favor of the a/r.
Date DSS-1894 "Notice of Decision" received by DSS **(required)**: _____

☐ Court Order in favor of the a/r.

☐ County administrative error: Date error discovered by DSS **(required)**: _____

Cause of error **(required)**: _____

Authorization limited to 12 months prior to discovery of error.

☐ Application opened/reopened when the applicant was discouraged from applying, encouraged to withdraw an application, or the application was improperly denied.

☐ County DSS learned of approval of an SSI/SDX application.

MANDATORY INFORMATION – Request will be denied if incomplete

Eligible dates in NCFAST for which override is needed: _____

Send notice of override approval to ☐ Beneficiary ☐ Responsible person
Responsible person: Name:_____
Address:_____

_____

Response to Request for Claims Override

To:_____ County:_____
(Income Maintenance Caseworker) (Department of Social Services)

From: DSS Support Unit
Division of Health Department

Beneficiary:_____MID: _____

OVERRIDE APPROVAL

Override authorization is **approved** for this beneficiary for the following date(s):

_____

_____

Advise the beneficiary to inform all medical providers to file outstanding claims directly to the NC Medicaid fiscal contractor, no later than_____.

If the beneficiary is unable to notify providers, or is deceased, the IMC ***must*** follow procedures in MA-2395/3530, Corrective Actions and Responsibility for Errors, IV C.9 and MA-2410, Medicare Enrollment and Buy-in VIII. C. D. and E.

OVERRIDE DENIAL

The override request is **denied** for all or part of the dates(s)_____because:

☐ Failure of the provider to file timely is not a basis for override.

☐ Failure of the beneficiary to notify the providers timely is not a basis for override.

☐ The claims filing time limit has not expired. No override is needed.

☐ The request does not meet policy guidelines. See M-AABD, MA-2395/3530, Corrective Actions and Responsibility for Errors.

☐ Other: _____
_____

_____

_____ _____
DATE DSS Support Analyst, DHB