NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

NOTICE OF OVERPAYMENT FOR MEDICAL ASSISTANCE

***Date*_____**

Program Code: _____
Program Case ID: _____
Social Security Number: _____
County Case ID: _____

(Debtor Name and Address Information Here)
_____
_____
_____

It has been determined that you and/or members of your household for whom you are financially responsible received Medicaid or NC Health Choice benefits that you were ineligible to receive. You currently owe $_____based on the medical expenses that we paid for ineligible medical coverage for you and/or members of your household. This includes expenses incurred during the period from _____ to_____due to unreported or inaccurately reported information.

IMPORTANT NOTE: The amount that you owe us is based on the medical expenses that have been paid to date. The amount that you owe us may increase if medical providers are paid for additional medical expenses that were incurred during the above stated period of ineligibility. If the amount of the overpayment increases, you will be notified of the increased amount.

All financially responsible adult household members are equally liable for this claim.

YOUR RESPONSIBILITIES

You must make every effort to repay the full amount you owe. If you have not previously made arrangements for full repayment, you should contact the Program Integrity Investigator at the_____County Department of Social Services to set up a voluntary repayment agreement.

If you fail to make arrangements to repay your medical assistance overpayment, or fail to make timely payments under your current repayment agreement, the county department of social services will initiate further collection action. Actions include, but are not limited to, civil court action, criminal court action, North Carolina income tax refund intercept, and wage garnishment.

HEARING RIGHTS

You have 60 days from the date of this letter to request a hearing from the_____County Department of Social Services. The 60th day is_____. If you do not request a local hearing by this date, you are not allowed to have one.

If you think we are wrong, you have the right to a hearing. This hearing will find out whether this action was correct. First, you can have a local hearing before an impartial official of the county department of social services. This hearing will be held within five calendar days of your request. The hearing can be postponed, for good reasons, for as much as ten more calendar days. To get your hearing, you must ask the county department of social services, either orally or in writing. The agency's address and telephone number are printed at the bottom of this letter.

If you think the decision in the local hearing is wrong, you can have a second hearing. The second hearing is before an impartial official of the North Carolina Division of Social Services. You must request the second hearing from the county department of social services, either orally or in writing.

You may have someone speak for you at your hearing such as a relative or attorney obtained at your expense. Free legal services may be available in your community. For more information, call the CARE-LINE Information and Referral Service toll free at 1-800-662-7030. TDD/Voice for the hearing impaired is also available through CARE-LINE.

You may ask the Program Integrity Investigator to see your benefits record and review with the agency the circumstances relating to this claim. If you ask, you may also see other information to be used at the hearing. You can get free copies of this information.

_____County Department of Social Services
_____
_____
_____, NC_____

(County DSS telephone number)
_____

Si necesita ayuda para entender esta carta de notificación de un pago excesivo por asistencia médica, comuníquese con la unidad de integridad de este programa en el departamento de servicios sociales del condado indicado arriba.