Erroneous Authorization Dates of Medicaid Eligibility

TO: _______________________________, Supervisor
    DMA Claims Analysis Unit
FROM: _______________________________, Medicaid Supervisor
    ________________________________ County DSS
DATE: __________________________________
RE:  Recipient Name: ____________________________________________
Recipient MID: ________________________________________________
Erroneous Date(s): ______________________________________________
Correct Date(s) From and To: ______________________________________

The following providers were contacted and notified of the erroneous eligibility authorization and requested not to bill Medicaid for services provided during the ineligible date(s) or to the ineligible individual:

  Provider Name(s) and Address(es)  Date Contacted

DMA-5172
Revised 10/2011