GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

TO ALL DISTRICT OF COLUMBIA MEDICAID RESIDENTS WHO PAID FOR MEDICAL EXPENSES THAT SHOULD HAVE BEEN PAID BY MEDICAID

If you do not speak and/or read English, please call (202) 724-7491 between 9:00 a.m. and 4:45 p.m. A representative will assist you.

Si usted no habla o lee inglés, por favor llame al (202) 724-7491 de 9:00 a.m. a 4:45 p.m. Un representate le ayudará. SPANISH

Si vous ne parlez pas et / ou lisez l'anglais , s'il vous plaît appelez (202) 724-7491 9:00-16:45. Un représentant vous aidera. FRENCH

如果您不会说或阅读英语，请于早上 9 点至下午 4 点 45 分之间致电 (202) 724-7491。我们将为您提供帮助。 CHINESE

한국어로 상담하시려면 오전 9:00 - 오후 4:45 시간대에 전화 (202) 724-7491번으로 연락주십시오. 고객 지원 담당자의 서비스를 받으실 수 있습니다. KOREAN

እንግሊዝኛ የማይናገሩ እና/ወይም የማያነቡ ከሆኑ፣ እባክዎ ወደ ስልክ ቁጥር (202) 724-7491 ከጠዋቱ 9:00 a.m. እስከ ቀኑ 4:45 p.m. ድረስ ይደውሉ። ተወካይ ያግዞታል። AMHARIC

Nếu quý vị không nói và/hoặc đọc được tiếng Anh, vui lòng gọi (202) 724-7491 giữa 9 giờ sáng và 4:45 chiều. Một nhân viên sẽ giúp đỡ quý vị. VIETNAMESE

If you paid for drug prescriptions, doctor visits, or hospitalizations during a time that you were eligible for Medicaid, you may be able to be reimbursed for the expenses.

REQUIREMENTS: You may be eligible for reimbursement during a period of time you or a family member were eligible for Medicaid if:

a. You paid for drug prescriptions, doctor visits, or hospitalizations; or
b. You are still paying a bill or are being asked to pay a bill by a pharmacy, clinic, doctor, or hospital for drug prescriptions, doctor visits, or hospitalizations.

If you believe that you are entitled to reimbursement, you must request reimbursement within six (6) months of the date you went to the pharmacy, clinic, doctor, or hospital, or within six (6) months of the date you learned you were eligible for Medicaid.

DEFINITION OF "ELIGIBLE FOR MEDICAID": The period of time for which you are "eligible for Medicaid" and may be eligible for reimbursement means:
1. The dates that the District of Columbia stated you (and/or your family members) were eligible for Medicaid.
2. The three (3) months before you submitted your application for Medicaid (and you were later found eligible).
3. The time after you filed your application for Medicaid and were waiting for a decision (and you were later found eligible).

4. Any time you were improperly denied eligibility of services:
a. If the District of Columbia improperly stopped your eligibility at the time of Medicaid renewal or recertification.
b. If the pharmacy, clinic, hospital, or doctor's office required you to pay because they said you were not on Medicaid when you actually were.
4. If, for a child under age 21 who is eligible for Medicaid, you were required to pay for any EPSDT service, including medical services, dental services, medication, medical equipment, supplies, or transportation services to Medicaid appointments.
5. If you have both Medicaid and Medicare and your pharmacy, clinic, hospital, or doctor required you to pay for any portion of the bill that Medicare does not pay.

IN ORDER TO BE REIMBURSED, YOU MUST:

1. Complete the enclosed Medicaid Reimbursement Form. Attach the receipt from the doctor, clinic, hospital or pharmacy that shows the expenses you paid.
2. If you do not have a receipt from the doctor, clinic, hospital or pharmacy, you may provide a signed and dated letter explaining why you do not have the receipt.
3. Submit the Medicaid Reimbursement Form with the receipt(s) (or the letter explaining why you do not have a receipt) to the address on the Medicaid Reimbursement Form.
4. Remember that you have six (6) months from the date you went to the pharmacy, clinic, doctor, or hospital or from the date you learned you were eligible for Medicaid to pay the expense to submit the Medicaid Reimbursement Form. If you do not have all of the information, you should submit as much information as you have available.
5. Reimbursement will only be made for expenses that should have been paid by Medicaid. You should carefully review the documents you submit to be sure that they are fully accurate.

IF YOU HAVE QUESTIONS OR IF YOU NEED HELP COMPLETING THE FORM

1. The Medicaid Recipient Claims Research Team of the D.C. Department of Health Care Finance (DHCF) at (202) 698-2009.
2. Terris Pravlik & Millian, LLP, 1816 12th Street, NW, Suite 303, Washington, DC 20009, (202) 682-0578, may assist you in completing the Medicaid Reimbursement form if you are a *Salazar* class member or want assistance to determine if you are a *Salazar* class member.
3. The RCRT must make a decision on your reimbursement claim within 90 days from the time you file your claim. If no decision is made within those 90 days, your claim will be treated as valid, and you will be paid within 15 days after the end of the 90 day period.
4. If you are not satisfied with the decision of the RCRT, you have a right to a fair hearing. You must file your request for a fair hearing within 90 days of the date of the decision by the RCRT. You may request a fair hearing by calling the Office of Administrative Hearings at (202) 442-9094. The Office of Administrative Hearings (OAH) is located at 441 4th Street, NW, Washington, DC 20001 -2714.
5. If you are not satisfied with the results of the fair hearing, you may appeal to the District of Columbia Court of Appeals. You must file your appeal within thirty (30) days after the OAH mails the final order of its decision.
6. You may be able to obtain free legal assistance to help you present your case at the hearing or on appeal. If you are a member of the class certified by the court in *Salazar v. District of Columbia*, Civil Action No. 93-452 (TSC) (D.D.C.), you may contact Terris, Pravlik & Millian, LLP at 1816 12th Street, NW, Suite 303 Washington, DC 20009 or (202) 682-0578. Free legal assistance for beneficiaries who are not members of the *Salazar* class may be available from the following organizations:

Bread for the City Legal Clinic, (202) 265-2400
Legal Aid Society, (202) 628-1161
Legal Counsel for the Elderly, (202) 434-2120
Neighborhood Legal Services, (202) 269-5100
University Legal Services, (202) 547-4747

MEDICAID REIMBURSEMENT REQUEST FORM

Today's date

DIRECTIONS: Complete and return, with receipts, within 6 months after you went to the clinic, doctor, hospital, or pharmacy – or 6 months of the date you learned you were eligible for Medicaid – to:

Recipients Claims Research Team
DC Department of Health Care Finance
441 4th Street NW.– 900 South
Washington, DC 20001

Please give as much information as you can. Attach copies of your receipts. If you don't have a receipt, attach a signed and dated letter that explains why you don't have it. If you're asking for reimbursement of expenses from more than 1 provider (like a doctor *and* a pharmacy), please use separate lines for each.

Your Name	Mailing address	Your phone numbers
		Day
Social Security Number of Medicaid Recipient		Evening
		Cell
Birth Date of Medicaid Recipient	Name & Medicaid ID # of Recipient Requesting Reimbursement	

SUMMARY OF INFORMATION ON ATTACHMENTS

For each expense (drug prescription, doctor visit or hospitalization), give this information*

Date (or estimated date) of expense	Name and address of pharmacy, clinic, doctor or hospital	How much you paid	How much you still owe	How much any other insurance paid	How much you want Medicaid to reimburse

*Attach a copies of any letters or bills from the pharmacy, clinic, doctor or hospital, or letters from credit collection companies about the bill.

I swear and declare, under penalty of perjury, that the statements I made on this paper and on any attached papers are true and correct

Signature

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I swear and declare, under penalty of perjury, that the statements I made on this paper and on any attached papers are true and correct.

Signature