MEDICAID ELIGIBILITY AUTHORIZATION LETTER

PURPOSE:

To provide an alternative care child and his/her alternative care provider with an official notice of Medicaid eligibility when:

- The alternative care child has not received a Medicaid card; or
- The Medicaid card has been lost.

Note: This form may be issued monthly as the ONLY ACCEPTABLE replacement for a lost, stolen or destroyed Medicaid card.

NUMBER OF COPIES AND DISTRIBUTION:

The CSW completes two (2) copies. The original is given to the alternative care provider and a copy is placed in the child's case record.

INSTRUCTIONS FOR COMPLETION:

From

Caseworker Name: Enter the name of the CSW completing the form.

Telephone Number: Enter the DFS County Office telephone number.

Date: Enter the date the form is mailed or given to the alternative care parent(s).

Address: Enter the street address, city, state and zip code of the DFS County Office.

To

Enter the alternative care parent's full name.

Address: Enter the street address, city, state and zip code of the alternative care parent(s).

Re

Case Name: Enter the child's full name.

Case Number: Enter the child's DCN.

This Form is Replacing a Lost Card/Letter: Children's Services staff will use this form primarily when a Medicaid card is lost or has not yet been received. Check "yes" or

"no" if appropriate to indicate if the form is replacing a lost Medicaid card. Indicate "no", if this letter is to suffice until the first identification card is received.

Note: The following are not applicable for a foster child: "Lock-In," "General Relief Case," and "Qualified Medicaid Beneficiary (QMB.)"

"Hospice Case" : The child may be receiving Hospice Care in rare instances when (s)he is terminally ill. If the child receives hospice care as indicated by the Division of Medical Services (DMS), enter "yes."

QMB: Leave blank.

Name: Enter the child's full name.

Emergency Room/Outpatient Restriction: Leave blank.

Five-Prescription Limit: Leave blank.

Medicaid Number: Enter the child's DCN.

Period of Coverage:

From - Enter the date of the first day of the month or the child's birthdate if a newborn's birthday is in the current month. The beginning date of Medicaid cannot precede the child's date of birth.

To - Enter the fourth day of the next month.

Hospice Information: Complete this section as requested only if the child is eligible for hospice care due to a terminal illness. Enter the child's name and the name and address of the contractor providing hospice care.

Medicaid Lock-In Program: Leave blank.

Third Party Liability: When issuing this form for an alternative care child with Third Party insurance coverage, indicate that insurance information on the form. Enter the full name of the child and the name of the insurance company. Enter the same insurance code as in Field 16 of Form TPL-1.

Caseworker Signature: The CSW signs the form.

INSTRUCTIONS FOR RETENTION

Retain this form in the child's case record for one (1) year.

MEMORANDA HISTORY: CS89-78