FORMS

Appendix B includes the Request for Payment/Override Form.

Providers are required to follow the procedures that are outlined in the *Quality Enhancement Plan Handbook.* This handbook can be obtained at the following website:

http://www.dhh.louisiana.gov/offices/publications.asp?ID=105&Detail=514

Providers are required to follow the procedures that are outlined in the *OAAS Critial Incident Reporting Policies and Procedures* manual and complete all forms as directed by this policy. The manual and forms can be obtained at the following website:

http://www.dhh.louisiana.gov/offices/page.asp?ID=105&Detail=8982

Reissued March 5, 2010
Replaces All Previous Issuances

REQUEST FOR PAYMENT/OVERRIDE FORM

OAAS-PF-08-014
Page 1 of 2

This form will be used for: _____ *Request for Payment of Transition Intensive Support Coordination* _____ *Request for payment of Transition Services* _____ *Request for Payment of Denied Claims*

Participant Name: _____ Medicaid # (13 digits): _____ Date of Birth: _____

Agency Name: _____ Agency Contact Person: _____ Agency Phone: _____

Agency Fax Number _____ Agency E-mail Address: _____

Population: Check One _____ EDA _____ ADHC _____ Other

Reason for Request: _____

PA Request is for: Begin Date: ___/___/___ End Date: ___/___/___ Initials Only: Date Support Coordination Agency Received the 18-W: ___/___/___

ATTACH ONLY THOSE DOCUMENTS NECESSARY TO JUSTIFY REQUEST: (DHH may request additional information.) Check documents that are attached.

_____ Approved CPOC _____ Progress Notes/Typed Chronology _____ CMS 1500 (completed) _____ Other:

DHH WILL NOT OVERRIDE TIMELY FILING LIMITS. IT IS THE RESPONSIBILITY OF EACH AGENCY TO RECONCILE ALL BILLINGS IN A TIMELY MANNER. DHH WILL REQUIRE A MAXIMUM OF FORTY-FIVE (45) CALENDAR DAYS TO PROCESS ALL REQUESTS AFTER RECEIPT OF ALL REQUIRED DOCUMENTATION. ANY REQUEST NOT CONTAINING THE NECESSARY INFORMATION WILL BE RETURNED AS INCOMPLETE AND CONSIDERED NOT RECEIVED.

TO BE COMPLETED BY OAAS: _____ APPROVED _____ DENIED _____ RETURNED (See Reason Below)

Notes: _____ If Denied or returned, please provide reason below:

OAAS Authorized Reviewer _____ Date _____

TO BE COMPLETED BY DHH/WAIVER ASSISTANCE AND COMPLIANCE (WAC) **IF APPLICABLE:** _____ APPROVED _____ DENIED _____ RETURNED (See Reason Below)

Notes: _____ If Denied or returned, please provide reason below:

DHH/WAC Authorized Reviewer _____ Date _____

INSTRUCTIONS FOR COMPLETING REQUEST FOR PAYMENT/OVERRIDE FORM

Step One - Indicate Reason for Use of Form.

1.) **Request for Payment of Transition Intensive Support Coordination (TISC)** – Use form to request payment for TISC services for up to four months prior to the individual transitioning out of a nursing facility.

2.) **Request for Payment of Transition Services** – Use form to request payment of funds expended by a designated purchaser prior to learning a participant will be unable to transition back into the community with a waiver opportunity..

3.) **Request for Payment of Denied Claims** – Use form to request payment of claims denied by UNISYS.

Step Two - Complete Demographic and Support Coordination Agency Information

Do not leave any blanks. Indicate the waiver or targeted case management population the request is for.

Step Three - Reason for Request:

Be specific. For "Request for Payment of Denied Claims", indicate the reason for the request and include the 3 digit Medicaid claim denial code from the Remittance Advice, i.e., observation services could not be completed because services did not begin until after the quarter, indicate what services did not begin in that quarter and the date the services did begin (this is needed so the PA for the provider can be canceled for that period). Denial Code 191

Step Four - PA Request is for:

Indicate the start and end date for the period of reimbursement you are requesting.

Step Five - Date Support Coordination Agency Received the 18-W:

Indicate the date the support coordination agency received the 18-W

Step Six - Support Documents Required:

Based on documentation provided, DHH will review and either approve, deny, or return the request.
Attach only those documents necessary to justify your request; i.e.

Request for Payment Reason 1.) Approved POC, progress notes, CMS 1500 (completed), and any other pertinent documents necessary.

Request for Payment Reason 2.) Copy of Pre-approved Transition Services Expense Planning and Approval (TSEPA) form, copy of revised POC budget sheet, copies of all receipts for expenditures from designated purchaser, copies of canceled checks, and narrative explaining why transition did not take place.

Request for Payment Reason 3.) If observation of services could not be completed submit program notes or typed chronology that supports request for payment. If denial is for late CPOC due to issues with requesting additional information, attach any correspondence received relative to the delay. **PROGRESS NOTES MUST BE LEGIBLE.**

Step Seven - First Signature Block

To be completed by OAAS Regional Office (R.O.) - Support coordinator agency will submit completed form and supporting documentation to OAAS R.O. for approval and signature. If denied or returned, the OAAS R.O. will give a detailed explanation for rejection, using an extra sheet if necessary. If approved, OAAS R.O. will e-mail a copy to the support coordination agency, a copy to SRI ljarrett@statres.com for payment, and a copy to susan.robinson@la.gov at OAAS State Office (S.O.).

Step Eight - Second Signature Block

TO BE USED BY DHH/WAIVER ASSISTANCE AND COMPLIANCE (WAC) SECTION, WHEN APPLICABLE.

Reissued March 5, 2010
Replaces All Previous Issuance

OAAS-PF-08-014
Page 2 of 2