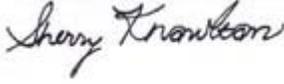


	MEDICAL ASSISTANCE BULLETIN COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE	
	SUBJECT Procedures for Submitting Invoices for Services Provided to Retroactively Eligible Newborns	BY  Sherry Knowlton Deputy Secretary for Medical Assistance Programs
NUMBER:	99-93-11	
ISSUE DATE:	December 6, 1993	
EFFECTIVE DATE:	December 6, 1993	

PURPOSE:

The purpose of this bulletin is to notify providers of the billing process for newborns found retroactively eligible for medical assistance benefits.

SCOPE:

This bulletin applies to all providers enrolled in the Medical Assistance Program.

BACKGROUND:

As the result of a recent policy interpretation, the Department of Public Welfare has revised its policy concerning newborn eligibility for medical assistance. This policy provides that a child born to a mother who is eligible for and receiving medical assistance at the time of birth is automatically eligible for medical assistance for one year from the date of the birth. This eligibility remains in effect as long as the child resides continuously in the mother's household.

DISCUSSION:

In compliance with this change, recipients will be notified, via a letter, of specific retroactive eligibility periods for the newborn. In line with the child's eligibility, the Office of Medical Assistance Programs (OMAP) will reimburse providers for medically necessary services furnished during the period an infant was retroactively eligible. The letter sent to affected mothers (or other caretakers) informs them that the OMAP is liable for unpaid bills for covered services furnished to newborns during the period of retroactive eligibility. Mothers/caretakers will be instructed to present the letter to a provider as verification that the newborn was eligible. A sample letter is attached to familiarize you with the format of the letters.

PROCEDURE:

If a mother/caretaker presents a letter that confirms retroactive eligibility for a newborn on the date you provided a medically necessary, covered service, please take the following steps:

1. Complete a medical assistance invoice in accordance with the instructions in the billing information section of your provider handbook.
2. If the eligibility verification letter indicates a service date that enables you to comply with the Department's 180-day time limitation for the submission of an original invoice, submit the completed invoice to the appropriate P.O. Box for your provider type.
3. If the eligibility verification time period exceeds the 180-day time limitation for submission of an original invoice, your invoice must be sent to the following address:

ATTENTION: Newborn Eligibility Payments
 Department of Public Welfare
 Division of Outpatient Programs
 P.O. Box 8046
 Harrisburg, Pennsylvania 17105

We will special handle these invoices, and these invoices only, on a one-time exception basis.

SAMPLE.....SAMPLE.....SAMPLE

CLIENT NOTICE

Your child, _____

(10 Digit Recipient Number)

(MAID #: CO./Rec. #/Category/CTR. DIG/Line #)

should have received Medical Assistance benefits for one year from his/her date of birth. Your child has been determined eligible and will receive medical assistance coverage during the following periods:

If you have unpaid medical bills for this child for the period(s) shown above that you received from a provider who accepts medical assistance, take this notice and your unpaid bills to your doctor, hospital or pharmacist. The doctor, hospital or pharmacist will submit an invoice(s) to Medical Assistance for payment.

If your child is under age one and not currently receiving medical assistance benefits, a medical card will be issued and Medical Assistance coverage will continue for at least one year from his/her date of birth. Your child can receive free check-ups, baby shots and other medical care with the medical card through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Call 1-800-KIDS-MED to schedule an appointment for your baby. Until you receive the medical card, take this notice with you to your doctor, hospital or pharmacist because he/she can use the recipient number shown on this notice to verify that your child is eligible for Medical Assistance benefits.

If you have any questions about this notice, please contact me at; _____.

Worker's Signature

Date

SAMPLE.....SAMPLE.....SAMPLE

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free inquiry line for your provider type.

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.