Reimbursement of Out-of-Pocket Expenditures for HSCSN Enrollees

Health Services for Children with Special Needs, Inc. (HSCSN) has a network of providers, doctors, pharmacies, hospitals, and vendors to provide you or your child with the health services and benefits you need. You should not have to pay out-of-pocket for covered services if you receive those services at a provider, pharmacy, or hospital within our network. Before paying for any prescription, doctor visit, or hospitalization you should call HSCSN to see if the service is covered. You can contact Customer Care at (202) 467-2737; TTY/TTD (202) 467-2709.

Before you pay out-of-pocket:

a. Show the provider, pharmacy, hospital, or vendor your HSCSN ID card.
b. Call HSCSN to see if you need precertification. Some services may require precertification from HSCSN before you can access them. If you do not have precertification from HSCSN, you may be responsible for paying for those services.
c. Call HSCSN if you need help locating an in-network provider. If you go to a doctor, pharmacy, hospital, or vendor that is not in HSCSN's network, you may have to pay out-of-pocket for services. Any service at an out-of-network provider requires precertification.

If you paid for prescription drugs, doctor visits, other provider visits or hospitalizations during a time you were enrolled with HSCSN, you may be able to be reimbursed for the expense. Claims must be submitted to HSCSN within 6 months after the medical expense was incurred. The general procedure for reimbursement requests is as follows:

1. The enrollee or their representative will submit a completed, signed, and legible Medicaid Reimbursement Request Form to HSCSN along will all supporting documents including: (a) detailed invoice of services provided, (b) receipt or proof of payment, (c) copy of prescription, and (d) proof of any other insurance coverage. Documents should be submitted to:

Health Services for Children with Special Needs (HSCSN)
Attn: Care Navigation
1101 Vermont Avenue, NW, 12th Floor
Washington, DC 20005

Or emailed to **carenavigation@hschealth.org**

2. HSCSN will verify the beneficiary's enrollment with HSCSN at the time the expense was incurred.

3. If the claimant was an HSCSN enrollee at the time the expense was incurred, HSCSN will notify the enrollee or their representative that their claim submission has been accepted.

4. Reimbursement will be subject to the following: (a) the individual was an enrollee of HSCSN at the time the expense was incurred, (b) the medical expense (*e.g.,* prescription drug, provider visit or hospitalization) was medically necessary and covered under Medicaid, and (c) the reimbursement request is submitted within six (6) months after the medical expense was incurred.

5. HSCSN will thoroughly review the reimbursement request and all supporting documents attached to the completed, signed, and legible Medicaid Reimbursement Request Form. Unless HSCSN asks for additional information to support your claim, no additional documents can be submitted after your claim submission is accepted.

6. HSCSN has sixty (60) days from the receipt of the reimbursement request to complete its investigation into the claim and mail to the claimant a final written determination. Final written determination consists of one of the following: (1) full payment of the claim, (2) partial payment of the claim with a full explanation of the reason(s) for the denial of part of the claim, or (3) denial of the claim with a full explanation of the reason(s) for the denial. All denials of reimbursement claims, in whole or in part, shall include a statement of the enrollee's right to appeal the decision.

For more information, please visit hscsnhealthplan.org, contact your Care Manager, or Call Customer Care at (202) 467-2737; TTY/TTD (202) 467-2709.

For more information visit www.hscsnhealthplan.org.
For reasonable accommodations please call (202) 467-2737.

If you do not speak and/or read English, please call 202-467-2737 between 7:00 a.m. and 5:30 p.m. A representative will assist you. **English.**

Si no habla o lee inglés, llame al 202-467-2737 entre las 7:00 a.m. y las 5:30 p.m. Un representante se complacerá en asistirle. **Spanish.**

የእንግሊዝኛ ቋንቋ መናገርና ማንበብ የማይችሉ ከሆነ ከጧቱ 7:00 ሰዓት እስከ ቀኑ 5:30 ባለው ጊዜ በስልክ ቁጥር 202-467-2737 በመደወል እርዳታ ማግኘት ይችላሉ። **Amharic.**

Nếu bạn không nói và/hoặc đọc tiếng Anh, xin gọi 202-467-2737 từ 7 giờ 00 sáng đến 5 giờ 30 chiều. Sẽ có người đại diện giúp bạn. **Vietnamese.**

如果您不能講和/或不能閱讀英語，請在上午 7:00 到下午 5:30 之間給 (202) 467-2737 打電話， 我們會有代表幫助您。**Traditional Chinese.**

영어로 대화를 못하시거나 영어를 읽지 못하시는 경우, 오전 7시 00분에서 오후 5시 30분 사이에 (202) 467-2737번으로 전화해 주시기 바랍니다. 담당 직원이 도와드립니다. **Korean.**

Si vous ne parlez pas ou lisez l'anglais, s'il vous plaît appeller 202-467-2737 entre 7:00 du matin et 5:30 du soir. Un représentant vous aidera. **French.**

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance.

HSCSN complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Health Services for Children with Special Needs, Inc. 1101 Vermont Avenue NW, Ste 1201, Washington, DC 20005 (202) 467.2737,
Family and Community Development Outreach Department 3400 Martin Luther King Jr. Avenue SE, Washington, DC 20032 (202) 580.6485
hscsnhealthplan.org

Children's National Health System, Accounts Payable
12211 Plum Orchard Dr
Silver Spring, MD 20904
Accounts Payable Phone: 301-572-5288
Accounts Payable Email: APIC@ChildrensNational.org

ACH Direct Deposit Enrollment Form

Children's National can submit payment to your organization via ACH credit to either your business checking or savings account. ACH payments are timely, secure, and a cost efficient means for receiving your payment. Please complete the information below to enroll your organization in ACH payments from Children's National Health System.

Vendor Information

Company Name:	
Address:	
Contact Name:	
Contact Email Address *(to receive ACH payment notifications):*	
Vendor ID # (for Children's National Use Only):	

Financial Institution Information

Financial Institution Name:	
Account Holder Name:	
Account Number:	
Routing Number:	
Account Type (checking or savings):	
Financial Institution Address:	

Authorized Signer:
Name:

Signature:

Date:

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 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 (RCRT) (Kenneth Gause and Pamela Stevenson) of the D.C. Department of Health Care Finance (DHCF) at (202) 698-2000.
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 working 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 (OAH) at (202) 442-9094. OAH is located at 441 4th Street, NW, Washington, DC 20001.
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) 480-8950 or (202) 791-3982
Legal Aid Society, (202) 628-1161
Legal Counsel for the Elderly, (202) 434-2120
Neighborhood Legal Services, (202) 832-6577
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:

Health Services for Children with Special Needs (HSCSN)
Attn: Care Navigation
1101 Vermont Avenue, NW, 12th Floor
Washington, DC 20005
(202) 467-2737 or email a copy of this form and all supporting documents to **carenavigation@hschealth.org**

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
Social Security Number of Medicaid Recipient		Day
		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