MEDI-CAL POTENTIAL OVERPAYMENT REPORTING WORK SHEET
INCOME OR OTHER HEALTH COVERAGE

Section I—Case Information

County ID	❒ IEVS ❒ Non-IEVS	Case status effective date(s) Active _____/_____/_____ Closed _____/_____/_____

RECIPIENTS INCLUDED IN POTENTIAL OVERPAYMENT (MFBU)

Name	Date of Birth	Social Security Number	Medi-Cal Eligibility Date	
			From	To

If additional space is needed, use the MC 224 A-S (Supplemental) and attach.

Section II—Possession of Other Health Coverage

Does recipient have other health coverage? ❒ Yes (check only if not reported) ❒ No

If yes, complete DHCS 6155 and send separately to: Department of Health Care Services, Other Health Coverage Section.

Is there also an income-related overpayment? ❒ Yes (complete Section III) ❒ No (go to Section IV)

Section III—Income Overpayment Computation

The share-of-cost should have increased for the period(s) _____

because _____

_____

and the county was not informed: (check all that apply)

❒ on the statement of facts ❒ within 10 days of change stated above ❒ On the status report

The overpayment is computed as follows: (County completes boxes 1–6.) (DHCS Investigations Branch completes boxes 7 and 8.)
For additional months of overpayment computations, use the MC 224 A-S (Supplemental) and attach.

1 Month/Year	2 Correct Net Income	3 Correct Maintenance Need	4 Correct Share-of-Cost (2–3)	5 Original Share-of-Cost Met	6 Potential Overpayment (4–5)	7 Amount Paid by Medi-Cal	8 Overpayment (Lower of 6 or 7)
	$	$	$	$	$	$	$

Section IV—County Worker Comments *(If additional space is needed, attach a separate sheet of paper.)*

Section V—County Worker Completing Form

Name (print)		County	
Signature	Date	EW number	Telephone number ( )

White—DHCS Investigations *Yellow—DHCS Investigations* *Pink—County*

GENERAL INSTRUCTIONS FOR COMPLETING FORM MC 224 A

If the potential overpayment for the entire period is less than $100, do not complete this form. The MC 224 A is completed in part by the county and in part by DHCS Investigations Office.

Section I (Completed by the County)

County ID — Enter the MFBU/MBU case number.

IEVS/Non-IEVS — Check the IEVS box if potential overpayment is due to IEVS or the Non-IEVS box if due to other means.

Case Status — Active-effective date/closed effective date; indicate when the case was opened and/or closed.

Recipients Included in the Potential Overpayment MFBU — Enter name, date of birth, and Social Security number of each MFBU member in potential overpayment and the beginning and ending dates of their Medi-Cal eligibility.

Section II—Possession of Other Health Coverage

Complete this section if the potential overpayment is due to a change in other health coverage. ***Note: If there is NO income-related potential overpayment, do not complete Section III. Complete Sections IV and V, and send these cases directly to Third Party Liability Branch, Health Insurance Section (see address in Article 16 H–7).***

Section III—Income Overpayment Computation (County Completes Columns 1–6)

Enter the dates of the potential overpayment period and brief reason why the SOC should have increased. Check whether the person:

A. Failed to report the information on the statement of facts at the time of application, ***or***

B. If already on Medi-Cal, failed to report within 10 days a change that would impact the SOC, ***or***

C. Failed to report the correct income on the status report.

If different reasons apply to different periods, link each reason to its respective period.

Column 1 — List in chronological order the consecutive months in which there was a potential overpayment. Use MC 224 A (Supplemental) if more space is needed.

Column 2 — Enter the correct net income for each of the months listed in which there was a potential overpayment.

Column 3 — Enter the correct maintenance need for each of the months listed in Column 1.

Column 4 — Subtract the amount in Column 3 from the amount in Column 2. The remainder is the correct SOC to be entered in this column.

Column 5 — Enter the original SOC the beneficiary met (paid or obligated) in each of the months listed in Column 1. This is needed to determine the difference between the original SOC and the newly calculated SOC.

Column 6 — For each month in the overpayment period, subtract the amount in Column 5 from the amount in Column 4; this amount is the potential overpayment for that month which must be entered in this column.

Columns 7 and 8 — DHCS Investigations Office will complete.

Section IV—County Worker Comments

Include county worker comments pertaining to the Medi-Cal potential overpayment.

Section V—County Worker Completing the Form

Print your name, county name, EW number, telephone number, and date. Sign the form.