DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

November 16, 1992

To: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons

Letter No.: 92-69

ACWDL# 92-62

SUBJECT: Andriola v. Kizer Forms

The purpose of this letter is to provide you with copies of the application, poster, denial notices, provider authorization letter (stuffer size), and draft provider bulletin that will be used in the implementation of the Andriola v. Kizer lawsuit. (For background information please refer to ACWDL# 92-62.)

Applications

The Data Systems Branch (DSB) in the Department of Health Services (DHS) will generate and issue an application (Enclosure 1) to individuals whom we have identified as receiving pregnancy-related services in the period covered by the lawsuit. (Please be aware that slight formatting changes may be made to the final version of this form.) In addition, we have developed a slightly different application (See Enclosure 2, Form MC 210-AND (Andriola) and the MC 210-AND (Andriola) SP (Spanish)) which the county will be responsible for issuing to any individual wishing to apply for Andriola benefits under this lawsuit who did not get an application from the department or who wishes a Spanish application. This Andriola Application (English and Spanish 20,000 each) will be stored in the DHS warehouse. We believe this number should meet the needs of the counties. However, once these applications are depleted, counties will be responsible for providing photocopies of the application form to anyone requesting one. (The county Andriola Coordinators have been provided camera ready copies in a separate letter.)

Poster

The Andriola Poster (See Enclosure 3) shall be displayed for a three month period beginning with the date the Department issues the applications. The projected beginning date is December 12, 1992. You will be notified of this date by E-Mail. A supply of posters will be sent to your county Andriola Coordinator by November 7, 1992.

Provider Authorization Letter

DHS will mail the stuffer-size Provider Authorization Letter (See Enclosure 4) along with the Medi-Cal card(s) being sent to eligible claimants for the retroactive months. This authorization is printed in English (on one side) and Spanish (on the other side). It contains instructions to the beneficiary on the use of the authorization and Medi-Cal card. In addition, the provider is instructed how to process the claim in accordance with direction given in the Andriola Provider Bulletin. At the applicant's request, providers shall photocopy the applicant's letter of authorization for their own use if applicants have more than one provider. The applicant is advised to retain the original for additional provider billing. However, in the case of a claimant losing the authorization or in error, leaving the original with the provider, we ask that the counties provide photocopies of the authorization to the applicant. (A camera ready copy will be sent to the Andriola Coordinators in the separate letter mentioned above.)

Denial Notices

The Andriola Denial Notice (See Enclosure 5, Forms MC 239-AND (Andriola) and the Spanish version MC 239-AND (Andriola) SP) will be sent to individuals who returned their application later than three months after the Date of Issuance or county date line stamp, where no record was found regarding prior benefits or information provided on the application could not be verified.

The back of the Denial Notice (See Enclosure 5, Forms MC 239-AND (Andriola) BACK and MC 239-AND (Andriola) SP (Spanish) BACK) has information on how individuals may request a state hearing if they are dissatisfied with the denial notice regarding their 60 Day Postpartum benefits. These state hearing request forms are modified versions of the NA Back 6 because the hearing requests are to be sent to DHS rather than the county welfare department.

If there are questions regarding this letter, please call Mary Maestas-Sandoval at (916) 657-1248 or Sharon Garcia at (916) 657-5327.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

YOU MAY RESERVE MEDICAL BENEFITS/Es posible que usted tenga derecho a recibir beneficios medicos.

OF ELIGIBILITY: 07/86, 08/86

ENCLOSURE 1

AA000001

HILL EDWARD
EDWARD HILL

P O BOX 698
SAN PABLO CA 94806

Birthdate: 01/01/65
MEDS-ID Number: 999-99-999
County-ID Number: 12-23-2222222-1-1

****
* Esta solicitud se relaciona a un posible reembolso *
* por concepto de gastos medicos que posiblemente usted *
* haya tenido con respecto a servicios relacionados al *
* embarazo, entre abril de 1986 y el 31 diciembre de *
* 1987. Si necesita una solicitud en espanol, lleve *
* esta forma a su departamento de bienestar del condado. *
****

RETROACTIVE 60 DAY POSTPARTUM PROGRAM APPLICATION (Andriola v. Kizer)

As a result of the Andriola v. Kizer lawsuit, the Department of Health Services (DHS) will retroactively implement the 60-Day Postpartum for the period April 7, 1986, to December 31, 1987.

60 Day Postpartum program
Under this program, women who applied for, were entitled to, and received Medi-Cal in the month pregnancy ended are eligible to have Medi-Cal pay for pregnancy-related and postpartum services in the postpartum period.

The postpartum period lasts for at least 60 days. The first day of the period begins on the day the pregnancy ends and lasts through the end of the month in which the 60th day falls.

Our Medi-Cal records indicate you may be one of the women covered by this lawsuit.

TO BE ELIGIBLE YOU MUST ANSWER YES TO THE FOLLOWING THREE QUESTIONS. IF YOU DO NOT ANSWER YES TO ALL QUESTIONS THIS LAWSUIT DOES NOT APPLY TO YOU.

1) Yes __ No __ Did your pregnancy end between March, 1986 through November, 1987 so that postpartum period would fall between April, 1986 to December 31, 1987?

2) Yes __ No __ Did you receive Medi-Cal in the month your pregnancy ended? If you had a share of cost, it had to be met. The answer to this is yes if Medi-Cal paid for any of your services in the month your pregnancy ended.

3) Yes __ No __ Did you have pregnancy-related or postpartum services not paid by Medi-Cal, insurance, or any other sources in the 60 days following the end of your pregnancy?

IF YOU ANSWER YES TO ALL OF THE ABOVE QUESTIONS. PLEASE PROVIDE THE FOLLOWING:

PLEASE PRINT:

Telephone Number: _____

Current Name(If Different From Front Side) _____

Current Address (If Different From Front Side) _____

IF YOU DO NOT ANSWER YES TO ALL OF THE ABOVE QUESTIONS, DO NOT COMPLETE THIS FORM. DISCARD THE FORM. DO NOT SEND OR GIVE THIS FORM TO YOUR COUNTY WELFARE DEPARTMENT OR STATE DEPARTMENT OF HEALTH SERVICES.

IF YOU ANSWER YES TO THE THREE QUESTIONS, SEND THIS FORM TO:

MEDI-CAL ELIGIBILITY BRANCH
ATTN: ANDRIOLA COORDINATOR
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

OR

YOUR LOCAL COUNTY WELFARE DEPARTMENT

FAILURE TO RETURN THIS WITHIN 3 MONTHS OF THE DATE OF ISSUANCE WILL RESULT IN A DENIAL OF ANY BENEFITS TO WHICH YOU MAY BE ENTITLED UNDER THIS LAWSUIT.

If you have any questions, please call your local department of social services or your county welfare department and ask to speak to the Andriola v. Kizer Coordinator concerning the Andriola v. Kizer lawsuit.

Signature: _____ Date: _____

APPLICATION
(ANDRIOLA v. KIZER)
YOU MAY DESERVE MEDICAL BENEFITS

ENCLOSURE 2

COUNTY

DATE GIVEN
TO THE APPLICANT: _____

DATE RETURN: _____

RETROACTIVE 60 DAY POSTPARTUM PROGRAM APPLICATION (Andriola v. Kizer)

As a result of the Andriola v. Kizer lawsuit, the Department of Health Services (DHS) will retroactively implement the 60-day Postpartum program for the period April 7, 1986 to December 31, 1987.

60 Day Postpartum program

Under this program, women who applied for, were entitled to, and received Medi-Cal in the month pregnancy ended are eligible to have Medi-Cal pay for pregnancy-related and postpartum services in the postpartum period.

The postpartum period lasts for at least 60 days. The first day of the period begins on the day the pregnancy ends and lasts through the end of the month in which the 60th day falls.

Our Medi-Cal records indicate you may be one of the women covered by this lawsuit.

TO BE ELIGIBLE YOU MUST ANSWER YES TO THE FOLLOWING THREE QUESTIONS. IF YOU DO NOT ANSWER YES TO ALL QUESTIONS THIS LAWSUIT DOES NOT APPLY TO YOU.

1) Yes ☐ No ☐ Did your pregnancy end between March, 1986 through November, 1987, so that your postpartum period would fall between April, 1986 to December 31, 1987.

2) Yes ☐ No ☐ Did you receive Medi-Cal in the month your pregnancy ended? If you had a share of cost, it had to be met. The answer to this is yes if Medi-Cal paid for any of your services in the month your pregnancy ended.

3) Yes ☐ No ☐ Did you have pregnancy-related or postpartum services not paid by Medi-Cal, insurance, or any other source(s) in the 60 days following the end of your pregnancy.

IF YOU DO NOT ANSWER YES TO ALL OF THE ABOVE QUESTIONS, DO NOT COMPLETE THIS FORM. DISREGARD THE FORM. DO NOT SEND OR GIVE THIS FORM TO YOUR COUNTY WELFARE DEPARTMENT OR STATE DEPARTMENT OF HEALTH SERVICES.

IF YOU ANSWER YES TO ALL OF THE ABOVE QUESTIONS, PLEASE COMPLETE THE REST OF THIS FORM.

PLEASE PRINT

Name: _____ Address: _____

Telephone: _____

Birthdate: _____ County Identification Number: _____

MEDS Identification: _____
Your Medi-Cal card or provider may have the MEDS Identification number.

Social Security Number: _____

Date Your Pregnancy Ended: _____

Your Name In the Month This Pregnancy Ended: _____

Name and Birthdate of Those Who Were in the Medi-Cal Case During the Period in Question:

NAMES	BIRTHDATES	SOCIAL SECURITY NUMBER

AFTER YOU COMPLETE THIS FORM, RETURN IT TO:

MEDI-CAL ELIGIBILITY BRANCH
ATTN: ANDRIOLA COORDINATOR
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

OR

YOUR LOCAL COUNTY WELFARE DEPARTMENT

FAILURE TO RETURN THIS WITHIN 3 MONTHS OF THE COUNTY DATE LINE STAMP WILL RESULT IN A DENIAL OF ANY BENEFITS TO WHICH YOU MAY BE ENTITLED UNDER THIS LAWSUIT.

If you have any questions, please call your local department of social services or your county welfare department and ask to speak to the Andriola v. Kizer Coordinator concerning the Andriola v. Kizer lawsuit.

Signature: _____ Date: _____

SOLICITUD
(ANDRIOLA VS. KIZER)
ES POSIBLE QUE USTED TENGA DERECHO A
RECIBIR BENEFICIOS MEDICOS

ENCLOSURE 2 continued

CONDADO

FECHA EN QUE SE DIO AL SOLICITANTE:

FECHA EN QUE SE REGRESA:

SOLICITUD PARA EL PROGRAMA DE POSPARTO DE 60 DIAS REOTRACTIVOS (Andriola vs. Kizer)

Como resultado de la demanda Andriola vs. Kizer , El Departamento de Servicios de Salud (DHS) pondrá en práctica retroactivamente el Programa de Posparto de 60 Días para el período del 7 de abril de 1986 al 31 de diciembre de 1987.

El Programa de Posparto de 60 Días

Bajo este programa, las mujeres que solicitaron, tenían derecho a recibir, y recibieron Medi-Cal durante el mes en que terminó el embarazo tienen derecho a que Medi-Cal pague los servicios relacionados al embarazo y de posparto durante el período de posparto.

El periodo de posparto dura por lo menos 60 días. El primer día del período comienza el día que termina el embarazo y dura hasta el fin del mes en que cae el día 60.

PARA REUNIR LOS REQUISITOS, USTED TIENE QUE CONTESTAR AFIRMATIVAMENTE A LAS SIGUIENTES TRES PREGUNTAS. SI USTED NO CONTESTA AFIRMATIVAMENTE A TODAS LAS PREGUNTAS, ESTA DEMANDA NO ES PERTINENTE A USTED.

1) Sí ☐ No ☐ ¿Terminó su embarazo entre marzo de 1986 y noviembre de 1987, a fin de que su período de posparto cayera entre abril de 1986 y el 31 de diciembre de 1987?

2) Sí ☐ No ☐ ¿Recibió usted Medi-Cal durante el mes en que terminó el embarazo? Si usted tenía una parte del costo, tuvo que cumplirse con la misma. La respuesta es afirmativa si Medi-Cal pagó cualquiera de sus servicios durante el mes en que terminó su embarazo.

3) Sí ☐ No ☐ ¿Tuvo usted servicios relacionados al embarazo o de posparto que no pagó Medi-Cal, algún seguro, u otra tercera persona responsable en los 60 días siguientes a la fecha en que terminó su embarazo?

SI USTED NO CONTESTO AFIRMATIVAMENTE A TODAS LAS PREGUNTAS ANTERIORES, NO COMPLETE ESTA FORMA. DESECHE LA FORMA. NO ENVIE O DE ESTA FORMA A SU DEPARTAMENTO DE BIENESTAR DEL CONDADO O AL DEPARTAMENTO ESTATAL DE SERVICIOS DE SALUD

SI USTED CONTESTA AFIRMATIVAMENTE A TODAS LAS PREGUNTAS ANTERIORES, POR FAVOR COMPLETE EL RESTO DE ESTA FORMA.

POR FAVOR ESCRIBA CON LETRA DE IMPRENTA

Nombre: _____ Dirección: _____

Teléfono: _____

Fecha de Nacimiento: _____ No. de Identificación del Condado: _____

No. de Identificación de MEDS: _____
Es posible que su proveedor tenga el número de Identificación de MEDS, o que esté en la tarjeta de Medi-Cal.

Número del Seguro Social: _____

Fecha en que Terminó su Embarazo: _____

Su Nombre Durante el Mes en que Terminó su Embarazo: _____

Nombres y Fechas de Nacimiento de Aquellos que Estaban en el Caso de Medi-Cal durante el Período en Cuestión:

NOMBRES	FECHAS DE NACIMIENTO	NUMERO DEL SEGURO SOCIAL
_____	_____	_____
_____	_____	_____
_____	_____	_____

DESPUES DE COMPLETAR ESTA FORMA, ENVIELA A:

MEDI-CAL ELIGIBILITY BRANCH
ATTN: ANDRIOLA COORDINATOR
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

O

A SU DEPARTAMENTO LOCAL DE BIENESTAR DEL CONDADO

EL NO HACERLO DENTRO DE UN PLAZO DE TRES MESES CONTADOS A PARTIR DE LA FECHA DEL SELLO DEL CONDADO, RESULTARA EN LA NEGACION DE CUALESQUIER BENEFICIOS A LOS CUALES USTED POSIBLEMENTE TENGA DERECHO A RECIBIR CONFORME A ESTA DEMANDA.

Si usted tiene alguna pregunta, por favor llame a su departamento local de servicios sociales de su departamento de bienestar del condado y pida hablar con el coordinador de Andriola vs. Kiser en referencia a la demanda Andriola vs. Kizer

Firma: _____ Fecha: _____

IMPORTANT NOTICE

ENCLOSURE 3

YOU MAY DESERVE MEDI-CAL BENEFITS!
ANDRIOLA V. KIZER LAWSUIT

A state court found that Medi-Cal wrongly denied some people their Medi-Cal cards. You may be one of these people:

- Were you or anyone in your household pregnant in 1986 or 1987?
- Did Medi-Cal pay for any of your/her pregnancy services in the month your/her pregnancy ended?
- Did you or anyone in your household have any pregnancy-related or postpartum services in the two months after your/her pregnancy ended which were not covered by Medi-Cal or health insurance?

If you answered yes to all of these questions, Medi-Cal may pay for the pregnancy-related and postpartum services you/she received in the two months after the pregnancy ended. Please call your local county welfare department or local department of public social services. Tell them you want an application for the Retroactive 60 Day Postpartum Program.

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF HEALTH SERVICES

AVISO IMPORTANTE

¿ES POSIBLE QUE USTED TENGA DERECHO
A RECIBIR BENEFICIOS DE MEDI-CAL?
DEMANDA DEL CASO ANDRIOLA VS. KIZER

Una corte estatal estableció que Medi-Cal, erróneamente, negó tarjetas de Medi-Cal a algunas personas.

Es posible que usted sea una de estas personas:

- ¿Estuvo usted o alguien en su hogar embarazada en 1986 o en 1987?
- ¿Pagó el Medi-Cal cualesquier servicios suyos o de ella en el mes en que terminó su embarazo?
- ¿Recibió usted o alguien en el hogar suyo servicios relacionados al embarazo o de posparto en los dos meses después de que terminó su embarazo, los cuales no cubrió Medi-Cal o un seguro de salud?

Si contestó sí a todas estas preguntas, posiblemente Medi-Cal pague los servicios relacionados al embarazo y de posparto que usted o ella hayan recibido en los dos meses después que terminó el embarazo. Por favor llame a su departamento local de bienestar del condado o de servicios sociales públicos. Dígales que desea una solicitud para el Programa de Posparto de 60 Días Retroactivos.

ENCLOSURE 4

ANDRIOLA AUTHORIZATION
IMPORTANT NOTICE
REGARDING YOUR MEDI-CAL CARDS

Applicant's Name _____
Address _____
Medi-Cal ID # _____
Old Share of Cost County ID # _____
Phone No. _____

Attached are the Medi-Cal cards you requested under the Andriola Court Order. They are issued in accordance with Title 22, California Code of Regulations (CCR), Section 50746 which permits county welfare departments to issue Medi-Cal cards more than one year after the month of service. Please give your doctor or medical provider this authorization along with your Medi-Cal card for the month(s) of service. If you have additional providers, please have the provider make a photocopy for his use and keep the original authorization for additional provider billing.

INSTRUCTIONS TO PROVIDER

Please refer to the Andriola Provider Bulletin for instructions on completing and submitting this form for billing.

Complete the fill in portion above (Applicant's name, address, Medi-Cal ID#, Old Share of Cost County ID #, Phone #).

Submit this authorization with the billing to:

Over-One-Year Claims Unit
EDS Federal Corporation
P.O. Box 13029
Sacramento, CA 95813-4029

If the applicant has more than one provider, please photocopy the original authorization for your use and return the original to the applicant for additional provider billing.)

ANDRIOLA AUTHORIZATION
IMPORTANT NOTICE
REGARDING YOUR MEDI-CAL CARDS

Applicant's Name _____
Address _____
Medi-Cal ID # _____
Old Share of Cost County ID # _____
Phone No. _____

Attached are the Medi-Cal cards you requested under the Andriola Court Order. They are issued in accordance with Title 22, California Code of Regulations (CCR), Section 50746 which permits county welfare departments to issue Medi-Cal cards more than one year after the month of service. Please give your doctor or medical provider this authorization along with your Medi-Cal card for the month(s) of service. If you have additional providers, please have the provider make a photocopy for his use and keep the original authorization for additional provider billing.

INSTRUCTIONS TO PROVIDER

Please refer to the Andriola Provider Bulletin for instructions on completing and submitting this form for billing.

Complete the fill in portion above (Applicant's name, address, Medi-Cal ID#, Old Share of Cost County ID #, Phone #).

Submit this authorization with the billing to:

Over-One-Year Claims Unit
EDS Federal Corporation
P.O. Box 13029
Sacramento, CA 95813-4029

(If the applicant has more than one provider, please photocopy the original authorization for your use and return the original to the applicant for additional provider billing.)

ANDRIOLA AUTHORIZATION
IMPORTANT NOTICE
REGARDING YOUR MEDI-CAL CARDS

Applicant's Name _____
Address _____
Medi-Cal ID # _____
Old Share of Cost County ID # _____
Phone No. _____

Attached are the Medi-Cal cards you requested under the Andriola Court Order. They are issued in accordance with Title 22, California Code of Regulations (CCR), Section 50746 which permits county welfare departments to issue Medi-Cal cards more than one year after the month of service. Please give your doctor or medical provider this authorization along with your Medi-Cal card for the month(s) of service. If you have additional providers, please have the provider make a photocopy for his use and keep the original authorization for additional provider billing.

INSTRUCTIONS TO PROVIDER

Please refer to the Andriola Provider Bulletin for instructions on completing and submitting this form for billing.

Complete the fill in portion above (Applicant's name, address, Medi-Cal ID#, Old Share of Cost County ID #, Phone #).

Submit this authorization with the billing to:

Over-One-Year Claims Unit
EDS Federal Corporation
P.O. Box 13029
Sacramento, CA 95813-4029

(If the applicant has more than one provider, please photocopy the original authorization for your use and return the original to the applicant for additional provider billing.)

ENCLOSURE 4 continued

AUTORIZACION ANDRIOLA
NOTIFICACION IMPORTANTE CON RELACION A SUS TARJETAS DE MEDI-CAL

ombre del Solicitante _____
irección _____
o. de Ident. de Medi-Cal _____
o. de Identificación del Condado para la Parte del
osto Antigua _____
o. de Teléfono _____

djuntas encontrará las tarjetas de Medi-Cal que usted
licitó bajo la Orden de la Corte conocida como
ndriola". Se le expiden en conformidad con la sección
0746 del Título 22, del Código de Ordenamientos de
alifornia (CCR), la cual permite a los departamentos de
enestar de los condados a expedir tarjetas de Medi-Cal
ás de un año después de transcurrir el mes en que se
oporcionó el servicio. Por favor dé esta autorización,
nto con su tarjeta de Medi-Cal para los meses de
rvicio, a su doctor o proveedor médico. Si tiene otros
oveedores, por favor pida al proveedor que haga una
tocopia para su uso, y conserve la autorización original
ra cobros de proveedores adicionales.

INSTRUCCIONES AL PROVEEDOR
(INSTRUCTIONS TO PROVIDER)

ease refer to the Andriola Provider Bulletin for
structions on completing and submitting this form for
lling.

mplete the fill in portion above (Applicant's name,
dress, Medi-Cal ID#, Old Share of Cost County ID #,
one #).

bmit this authorization with the billing to:

Over-One-Year Claims Unit
EDS Federal Corporation
P.O. Box 13029
Sacramento, CA 95813-4029

the applicant has more than one provider, please
otocopy the original authorization for your use and
rn the original to the applicant for additional
ovider billing.)

AUTORIZACION ANDRIOLA
NOTIFICACION IMPORTANTE CON RELACION A SUS TARJETAS DE MEDI-CAL

Nombre del Solicitante _____
Dirección _____
No. de Ident. de Medi-Cal _____
No. de Identificación del Condado para la Parte del
Costo Antigua _____
No. de Teléfono _____

Adjuntas encontrará las tarjetas de Medi-Cal que usted solicitó bajo la Orden de la Corte conocida como "Andriola". Se le expiden en conformidad con la sección 50746 del Título 22, del Código de Ordenamientos de California (CCR), la cual permite a los departamentos de bienestar de los condados a expedir tarjetas de Medi-Cal más de un año después de transcurrir el mes en que se proporcionó el servicio. Por favor dé esta autorización, junto con su tarjeta de Medi-Cal para los meses de servicio, a su doctor o proveedor médico. Si tiene otros proveedores, por favor pida al proveedor que haga una fotocopia para su uso, y conserve la autorización original para cobros de proveedores adicionales.

INSTRUCCIONES AL PROVEEDOR
(INSTRUCTIONS TO PROVIDER)

Please refer to the Andriola Provider Bulletin for instructions on completing and submitting this form for billing.

Complete the fill in portion above (Applicant's name, address, Medi-Cal ID#, Old Share of Cost County ID #, Phone #).

Submit this authorization with the billing to:

Over-One-Year Claims Unit
EDS Federal Corporation
P.O. Box 13029
Sacramento, CA 95813-4029

(If the applicant has more than one provider, please photocopy the original authorization for your use and return the original to the applicant for additional provider billing.)

AUTORIZACION ANDRIOLA
NOTIFICACION IMPORTANTE CON RELACION A SUS TARJETAS DE MEDI-CAL

Nombre del Solicitante _____
Dirección _____
No. de Ident. de Medi-Cal _____
No. de Identificación del Condado para la Parte del
Costo Antigua _____
No. de Teléfono _____

Adjuntas encontrará las tarjetas de Medi-Cal que usted solicitó bajo la Orden de la Corte conocida como "Andriola". Se le expiden en conformidad con la sección 50746 del Título 22, del Código de Ordenamientos de California (CCR), la cual permite a los departamentos de bienestar de los condados a expedir tarjetas de Medi-Cal más de un año después de transcurrir el mes en que se proporcionó el servicio. Por favor dé esta autorización, junto con su tarjeta de Medi-Cal para los meses de servicio, a su doctor o proveedor médico. Si tiene otros proveedores, por favor pida al proveedor que haga una fotocopia para su uso, y conserve la autorización original para cobros de proveedores adicionales.

INSTRUCCIONES AL PROVEEDOR
(INSTRUCTIONS TO PROVIDER)

Please refer to the Andriola Provider Bulletin for instructions on completing and submitting this form for billing.

Complete the fill in portion above (Applicant's name, address, Medi-Cal ID#, Old Share of Cost County ID #, Phone #).

Submit this authorization with the billing to:

Over-One-Year Claims Unit
EDS Federal Corporation
P.O. Box 13029
Sacramento, CA 95813-4029

(If the applicant has more than one provider, please photocopy the original authorization for your use and return the original to the applicant for additional provider billing.)

MEDI-CAL
IMPORTANT NOTICE OF ACTION
DENIAL OF ANDRIOLA BENEFITS

(County Stamp)

ENCLOSURE 5

MEDS ID:

DENIAL FOR: _____

_____

_____

Your application for pregnancy-related and postpartum Medi-Cal benefits, without a share of cost, under the Andriola v. Kizer lawsuit (60 day postpartum services following the month pregnancy ended) has been denied.

☐ You returned your application later than 3 months after the Date of Issuance or county date line stamp.

☐ No record was found regarding your prior benefits or information provided on the application cannot be verified.

This denial notice will not affect any Medi-Cal Benefits that you may be currently receiving.

If you are dissatisfied with this action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. Please see the reverse side of this form for details regarding this process.

This notice is a result of a court decision in the case Andriola v. Kizer/Case Number 657296, Superior Court of California, County of Santa Clara.

For additional information, please contact the:

Andriola Coordinator
State Department of Health Services
714 P Street, Room 1692
Sacramento, CA 95814
(916) 657-5327 or
(916) 657-1248

)UR HEARING RIGHTS

Ask For a State Hearing

The right side of this sheet tells how.

- You only have 90 days to ask for a hearing.
- The 90 days started the day after we mailed this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

Keep Your Same Benefits While You Wait For a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

☐ Cash Aid ☐ Food Stamps

Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free:	1-800-952-5253
If you are deaf and use TDD call:	1-800-952-8349

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

You may get free legal help at your local legal aid office or welfare rights group.

Other Information

Child Support: The District Attorney's office will help you collect child support even if you are not on cash aid. There is no cost for this help. If they now collect child support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask.

Hearing File: If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W & I Code Section 10950)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page and send or take it to:

Administrative Adjudications Division
State Department of Social Services
744 P Steet, Mail Station 19-37
Sacramento, CA 95814

You may also call 1-800-952-5253.

HEARING REQUEST

I want a hearing because of an action by the Department of Health Services regarding the Andriola v. Kizer lawsuit for my 60 day Retro Postpartum Medi-Cal Benefits.

Here's why: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I will bring this person to the hearing to help me (name and address, if known):

_____

_____

_____

I need an interpreter at no cost to me. My language or dialect is: _____

My name: _____

Address: _____

_____

Phone: _____

My signature: _____

Date: _____

MEDI-CAL
NOTIFICACION DE ACCION IMPORTANTE
NEGACION DE LOS BENEFICIOS ANDRIOLA

(Sello del Condado)

ENCLOSURE 5 continued

IDENTIFICACION DE MEDS:

NEGACION PARA: _____

_____

_____

Se ha negado su solicitud para beneficios de Medi-Cal relacionados al embarazo y de posparto, sin una parte del costo, bajo la demanda Andriola vs. Kizer (servicios de posparto de los 60 días que siguen al mes en que terminó el embarazo).

- ☐ Usted regresó su solicitud después de los 3 meses de la Fecha de Emisión o la fecha del sello del condado.
- ☐ No se encontró ningún registro concerniente a su beneficios anteriores, o no se puede comprobar la información proporcionada en la solicitud.

Esta notificación de negación no afectará ningunos Beneficios de Medi-Cal que posiblemente usted esté recibiendo actualmente.

Si usted no está satisfecho con esta acción, puede solicitar una audiencia con el estado ante un Juez de Leyes Administrativas del Departamento de Servicios Sociales del Estado. Por favor vea el reverso de esta forma el cual contiene los detalles referentes a este proceso.

Esta notificación se hace como resultado de una decisión de la corte en el caso Andriola vs. Kizer/Número del Caso 657296, Corte Superior de California, Condado de Santa Clara.

Para información adicional, por favor comuníquese con el:

Andriola Coordinator
State Department of Health Services
714 P Street, Room 1692
Sacramento, CA 95814
(916) 657-5327 or
(916) 657-1248

MC 239 AND (SP) (9/92)

IS DERECHOS A UNA AUDIENCIA

'a pedir una audiencia con el estado.

El lado derecho de esta página le indica cómo hacerlo.

- Usted tiene solamente 90 días para solicitar una audiencia.
- Los 90 días comenzaron un día después de la fecha en que le enviamos esta notificación.
- Tiene menos tiempo para pedir una audiencia si desea seguir recibiendo los mismos beneficios.

ra conservar sus mismos beneficios mientras espera una diencia

Tiene que solicitar una audiencia antes que la acción entre en vigor.

- Su asistencia monetaria permanecerá sin cambios hasta que se lleve a cabo su audiencia.
- Su Medi-Cal permanecerá sin cambios hasta que se lleve acabo su audiencia.
- **Sus estampillas para comida permanecerán sin cambios** hasta que se lleve a cabo la audiencia o hasta el fin de su período de certificación; lo que ocurra primero.
- Si la decisión de la audiencia indica que estamos en lo correcto, usted nos deberá cualquier dinero o estampillas para comida que haya recibido.

ara que se descontinúen ahora sus beneficios

Si usted desea que se descontinúen su asistencia monetaria o sus estampillas para comida mientras espera una audiencia, marque uno de los casilleros.

☐ Asistencia monetaria ☐ Estampillas para comida

'ara que le asistan

Puede obtener información acerca de sus derechos a una audiencia o asesoría legal gratuita llamando al teléfono de información del estado.

Número gratuito	1-800-952-5253
Si es sordo y usa TDD:	1-800-952-8349

Si no desea venir a la audiencia solo, puede traer un amigo, un abogado o cualquier otra persona, pero usted debe hacer los arreglos para traer a esa otra persona.

Es posible que pueda obtener ayuda legal gratuita en su oficina local de asesoramiento legal (legal aid) o de su grupo de derechos de recipientes de asistencia pública.

Otra Información

Mantenimiento de hijos: La oficina del Fiscal del Distrito le ayudará a cobrar mantenimiento de hijos aun cuando no esté recibiendo asistencia monetaria. Esta asistencia es gratuita. Si en la actualidad están cobrando mantenimiento de hijos a su nombre, ellos continuarán haciéndolo hasta que usted les dé aviso por escrito indicándoles que paren. Le enviarán a usted cualesquier cantidades de mantenimiento que cobren. Se quedarán con las cantidades vencidas cobradas que se le deban al condado.

Planificación familiar: Su oficina de bienestar le proporcionará información cuando usted la solicite.

Expediente de la audiencia: Si usted solicita una audiencia, la oficina de audiencias con el estado formará un expediente. Usted tiene el derecho de examinar este expediente. El Estado puede dar su expediente al departamento de bienestar, al Departamento de Salud y Servicios Humanos de los Estados Unidos y al Departamento de Agricultura de los Estados Unidos. (Sección 10950 del Código de Bienestar e Instituciones)

COMO PEDIR UNA AUDIENCIA CON EL ESTADO

La mejor manera de solicitar una audiencia es llenar esta página y enviarla a:

Administrative Adjudications Division
State Department of Social Services
744 P Steet, Mail Station 19-37
Sacramento, CA 95814

Tambien puede llamar al 1-800-952-5253.

PETICION PARA UNA AUDIENCIA

Deseo solicitar una audiencia a causa de una acción ejercitada por el Departamento de Servicios de Salud, acerca de mis beneficios retroactivos del programa de posparto de 60 días del Medi-Cal, como resultado del juicio conocido como Andriola vs. Kizer.

La razón es la siguiente: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

La siguiente persona vendrá conmigo a la audiencia a ayudarme (nombre y dirección si los sabe):

_____

_____

_____

Necesito un intérprete sin costo para mí.

Mi idioma es el: _____

Mi nombre: _____

Dirección: _____

_____

Teléfono: _____

Mi Firma: _____

Fecha: _____

DRAFT ENCLOSURE 6

Retroactive 60-day Postpartum Program: Andriola v. Kizer

The Retroactive 60-day Postpartum Program is a result of the Andriola v. Kizer court decision concerning the federally mandated 60-day postpartum program.

60-day Postpartum Program

The 60-day postpartum program specifies that women, who applied for, were eligible for, and received Medi-Cal benefits on the date pregnancy ended, are eligible for continuation of pregnancy-related and postpartum services for a limited period of time. This time period begins the day pregnancy ends, and continues through the end of the month in which 59 days after the end of the pregnancy occurs, for a minimum coverage period of 60 days.

Andriola v. Kizer Eligibility Retroactive

Federal law had specified that this program be effective April 7, 1986, but the Department of Health Services (DHS) did not implement the program until January 1, 1988. Therefore, Andriola v. Kizer requires DHS to retroactively issue 60-day postpartum benefits to eligible recipients during the April 7, 1986 to December 31, 1987 period.

Eligibility Notification: Andriola Authorization Notice

Medi-Cal ID cards are permitted to be issued to recipients more than one year after the month of services for limited reasons (Title 22, *CCR*, Section 50746). Beginning December 12, 1992, eligible 60-day postpartum recipients will be issued an *Andriola Authorization Notice* and a zero Share of Cost 60-day Postpartum Program Medi-Cal ID card for the months of services rendered.

Processing Form

Recipients will present the authorization notice and Medi-Cal ID card to their provider.

You are to complete the fill-in portion of the notice (Applicant's Name, Address, Medi-Cal ID #, old Share of Cost ID #, Phone No.) and submit it with the claim requesting payment for 60-day postpartum services. The old Share of Cost County ID number can be obtained from the original claim/Explanation of Benfit (EOB), original Medi-Cal ID card, or the original MC-177. You can obtain the Medi-Cal ID number from the retroactive card presented by the recipient.

Note: If the applicant has more than one provider, please photocopy the original authorization for your use and return the original to the applicant for additional provider billing.

DRAFT

DRAFT

 continued

Processing Underpayment Claims with Zero Share of Cost

Providers are required to reimburse recipients for Medi-Cal program underpayments (Title 22, *CCR*, Section 51471.1). Providers submitting claims with a zero Share of Cost are to complete either a *Claims Inquiry Form* (CIF) or a *Professional/Supplier Claim* form (40-1) based on the following criteria:

Submit a CIF

- If a recipient paid or was obligated to pay an original Share of Cost, and Medi-Cal was billed for the balance of the charges, you must submit a *Claims Inquiry Form* (CIF) with the *Andriola Authorization Notice* attached. (Do not submit a new claim. It will be considered a duplicate and payment will be denied.)

  Once the CIF is approved and payment is received, you must reimburse the recipient for any Share of Cost previously paid, or eliminate the outstanding Share of Cost obligated for the service billed.

- Use the old Share of Cost County ID number on the CIF.

Submit a Claim

- If the recipient paid or was obligated to pay an original Share of Cost, and Medi-Cal was not billed because the charges equaled the Share of Cost collected, you can bill Medi-Cal for the services rendered by completing an *Professional/Supplier Claim* form (15-1).

To bill for a zero Share of Cost, enter

- "8" in the *Billing Limit. Exception* box (21), and
- "0" (zero) in the *Patient's Share of Cost* box (124).

Be sure to submit the claim with the *Andriola Authorization Notice* attached.

Where to Submit Claims

Retroactive 60-day postpartum CIFs or claims should be submitted to:

ATTN: Over-One-Year Claim Unit
E.D.S. Federal Corporation
P.O. Box 13029
Sacramento, CA 95813-4029