STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 657-2941

August 19, 1993

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

Letter No.: 93-61

STATE BUY-IN PROBLEM REPORT--DHS 6166 (6/93)

The purpose of this letter is to notify county staff of the availability of a revised State Buy-In Problem Report form (DHS 6166 (6/93)).

Enclosed is a copy of the new Buy-In Problem Report form to be used effective immediately. The form has been revised to include space for Specified Low Income Medicare Beneficiaries (SLMB) problem identification and another line to be written in for future programs.

Instructions for completion are on the reverse and the State Department of Health Services mailing address is positioned to fit in a window envelope for your convenience. The revised form should simplify reporting and ensure pertinent information is available for timely resolution of Buy-In problems.

Please destroy the old DHS 6166 (4/90) forms and notify your staff to use the new DHS 6166 (6/93) form. The form may be ordered form the Department of Health Services warehouse at the address below:

Department of Health Services
1037 No. Market Blvd., Suite 9
Sacramento, CA 95834
(916) 928-9203

We suggest that your staff re-evaluate Buy-In problems to see if they still exist prior to submitting a Buy-In Problem Report. If you have any questions or need additional information regarding the DHS 6166 (6/93) form, please contact Charlotte Gordon at (916) 323-9693.

Sincerely,

ORIGINAL SIGNED BY
Angeline Mrva for

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

STATE BUY-IN PROBLEM REPORT
(Medicare Part A and B)

See reverse for Privacy Statement and Instructions for Completing Form.

A. COUNTY REPRESENTATIVE INFORMATION

Name	County District	E/W Number

Telephone Number	Date Submitted	Response Requested
( )		☐ Yes ☐ No

County Mailing Address

B. BENEFICIARY IDENTIFICATION

Name (First) (Middle) (Last)

Date of Birth (Month/Day/Year) Sex: ☐ M ☐ F

Social Security Number

Medicare/Railroad Claim (HIC) Number

☐ Alien Resident
Date of Entry To USA _____

C. PROGRAM ELIGIBILITY/CASE IDENTIFICATION

	County	Aid	7-Digit Serial Number	FBU	Person Number	Eligibility Date	Approval Date
	FILL IN BOTH CASE IDENTIFICATION LINES IF MEDI-CAL AND QMB (DUAL ELIGIBLE).						
( ) Medi-Cal							
( ) QMB							
( ) SLMB							
( )							

Remarks—Explain Buy-In Problem

( ) Attachments

D. STATE USE ONLY

☐ Medicare Claim No. (HIC) being reported is incorrect. The correct number is: _____.
☐ Accretion confirmed on _____ / _____ Effective Date: QMB Part A _____ Part B _____
☐ Deletion confirmed on _____ / _____ Effective Date: QMB Part A _____ Part B _____
☐ Buy-in closed period coverage. Date forwarded _____ / _____ Effective: _____ To: _____
☐ Medi-Cal card corrected to remove Medicare indicator 1,2,3.
☐ Accretion not possible due to: _____.

☐ Medi-Cal ☐ QMB ☐ SLMB ☐ _____ eligibility on MEDS not being reported currently.
☐ QMB beneficiary is not currently enrolled for Part A benefits. Have beneficiary go to SSA and apply during general/open enrollment period (January through March; effective in July).
☐ Part A benefits terminated effective: _____. ☐ Part B benefits terminated effective: _____.
☐ Medi-Cal ☐ QMB ☐ SLMB ☐ _____ beneficiary is not currently enrolled for Part B benefits. Have beneficiary go to SSA and apply.

☐ Please allow 120 days for processing.

Remarks:

_____ (916) _____ _____

Medicare Premium Payment Representative | Telephone Number | Date

This information is requested by the State of California under Section 10850 of the Welfare and Institutions Code in order to resolve complaints and problems received regarding the State payment of Medicare premiums. Completion of the form is voluntary and the consequences for not providing the information will result in unresolved problems and, potentially, no State payment of premiums. The information will be provided to the State Department of Health Services, Premium Payment Unit.

Mail to:

State of California
Department of Health Services
Medicare Premium Payment Unit
P.O. Box 1287
Sacramento, CA 95812-1287

INSTRUCTIONS FOR COMPLETION OF DHS 6166 FORM

Please include the following:

A. County Representative Identification

- Eligibility worker's name
- Area code and telephone number
- County district number and eligibility worker number
- Date submitted
- Check to indicate whether a State response is requested for this complaint
- Complete mailing address (response will not be returned without this information)

B. Beneficiary Identification

- Complete name, include any AKAs
- Date of birth using MM/DD/YY format
- Sex
- Social Security number
- Medicare/Railroad Health Insurance Claim (HIC) number
- Date of entry to USA, when reporting status of alien resident

C. Program Eligibility/Case Identification

- Complete Medi-Cal Number, Eligibility Date (for Medi-Cal including retro-active months of entitlement) and Approval Date (for Buy-in, determination can be no earlier than month of application and may be later). For example:

  1) Applied for Medi-Cal – April 1993
  2) Approval Date – May 1993
  3) Medi-Cal Effective Date – January 1993
  4) Buy-in Effective Date – July 1993

- Remarks—provide an explanation of the Buy-in problem.
- Check if any documents are attached.

D. State Use Only

- Medicare Premium Payment's response, if requested in A, above.