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August 27, 1993

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

Letter No. 93-63

HUNT V. KIZER: POLICY AND PROCEDURES FOR APPLYING OLD MEDICAL BILLS TOWARD SHARE OF COST; OTHER PROVISIONS

REF. All County Welfare Directors Letters No.: 89-87, 89-111, 90-11 90-45, 90-75, 90-80, 90-81, and "EMC2 DHS" E-Mail number #90188 (December 31, 1990), number #90169 (December 5, 1990) and number #91060 (March 28, 1991).

PART 1: INTRODUCTION AND OVERVIEW OF NEW PROVISIONS OF THE HUNT V KIZER LAWSUIT

INTRODUCTION

This All County Welfare Directors Letter (ACWDL) transmits Hunt policy and procedure which counties must implement pursuant to the final settlement agreement in the Hunt v Kizer lawsuit. This ACWDL delineates new Hunt policies and procedures and updates old Hunt policies and procedures from previous Department of Health Service's (DHS) ACWDLs and E-Mails. For purposes of county implementation of Hunt policy, the previous Hunt ACWDLs, 89-87, 89-111, 90-11, 90-45, 90-75, 90-80, 90-81, and "EMC2 DHS" E-Mails, number #90188 (December 31, 1990), number #90169 (December 5, 1990) and number #91060 (March 28, 1991), are hereby superseded. Because this ACWDL's interim Hunt policy and procedures implement several time-limited procedures, this ACWDL will be revised after the expiration of the effective period of these time-limited procedures. The future revision of this ACWDL will be published as an insert to the Medi-Cal Eligibility Manual Procedures and will become Section H of Article 19 on Share of Cost. This future revision should be available to counties in February, 1994.

The effective date for these policies and procedures will be October 5, 1993 and counties must implement the policies and procedures transmitted by this ACWDL by this date. This date is the distribution date for the final Hunt

informational notice. This informational notice (comprehensive beneficiary notice), titled "Your Rights To Use Old Medical Bills To Meet Your Share of Cost" (attached as Exhibit B), will be mailed by the Department of Health Services to those persons who have been Medi-Cal beneficiaries with a Share of Cost (SOC) in one or more months from July 1, 1988 through July 23, 1993. This informational notice, which supersedes previous Hunt informational (beneficiary) notices will summarize benefits and remedies provided by the Hunt Settlement Agreement for beneficiaries.

OVERVIEW OF THE PROVISIONS OF THE HUNT V KIZER FINAL SETTLEMENT AGREEMENT

Previous to the Hunt v Kizer lawsuit, Medi-Cal beneficiaries could apply toward a particular month's SOC only those medical expenses incurred in the same month. Beneficiaries were not permitted to apply medical bills for medical expenses incurred in previous months (old medical bills) toward their SOC for a current month, nor could beneficiaries save medical bills from current months and apply them as old medical bills toward a future month's SOC.

In 1989, the Department of Health Services (DHS) reversed the above restrictions per the Hunt v Kizer lawsuit. Beneficiaries were allowed to apply medical bills from previous months toward their current month's SOC provided these old medical bills were unpaid at the time they were submitted to the county. Beneficiaries were also permitted to save old or current medical bills and apply them as old medical bills toward their SOC in a future (later) month, provided these old medical bills remained unpaid.

STANDARD HUNT REMEDY (FOR UNPAID OLD MEDICAL BILLS)

Under the terms of the "Stipulation for Entry of Judgment for Permanent Injunction," the final settlement agreement for the Hunt v Kizer lawsuit, beneficiaries may continue to apply unpaid old medical bills toward their SOC. This ongoing remedy, called the Standard Hunt Remedy (p. 6 of this ACWDL)will continue indefinitely. Counties will be familiar with this Standard Hunt remedy. It has been in effect under the terms of the Preliminary Injunction since 1989 and has already been implemented by the counties.

LIMITED-TIME REMEDIES

In addition the final settlement agreement provides beneficiaries with three new, LIMITED-TIME opportunities (called remedies) for using old medical bills to meet their SOC. These three new, limited-time remedies (see pp. 7, 8 & 13 of this ACWDL) are listed below.

1. PAID OLD MEDICAL BILL REMEDY: Beneficiaries may apply, under certain circumstances, their paid or unpaid old medical bills toward their SOC (Hunt v Kizer Paid Old Medical Bill Remedy, p. 7 of this ACWDL.)

2. RETROACTIVE MEDI-CAL CARD REMEDY: Beneficiaries may apply, under certain circumstances, their paid or unpaid old medical bills toward

their SOC in specified past months in order to obtain a retroactive Medi-Cal card for those months (Hunt v Kizer Retroactive Medi-Cal Card Remedy, p. 8 of this ACWDL.)

3. OPTIONAL REMEDY: Beneficiaries who have medical bills that could have been used to obtain a retroactive card under paragraph 2, may, under certain circumstances, instead apply these medical bills to their SOC (Hunt v Kizer Optional Remedy, p. 13 of this ACWDL.)

These time limited remedies are effective for a period of 6 months, commencing October 5, 1993 and expiring April 5, 1994. After this 6 month period has expired, these time-limited remedies will be unavailable to beneficiaries. As previously stated, DHS will then revise these procedures to eliminate the dated provisions and distribute to counties these revised procedures as permanent Hunt procedures for insertion into the Medi-Cal Eligibility Manual Procedures.

ADDITIONAL NEW BENEFICIARY BENEFITS

The final settlement agreement also permits beneficiaries: 1) to submit current as well as old medical bills to the county for processing toward their SOC (Section VIII of this document, p. 23 of this ACWDL) and 2) to use credit card or collection agency statements as evidence of medical expenses (Section VI of this document, p. 19.).

TRANSMITTAL OF FINAL SETTLEMENT AGREEMENT

DHS will transmit a copy of the Hunt v Kizer Settlement Agreement to counties when DHS receives a copy of the finalized Settlement Agreement from plaintiffs.

PART 2: INTERIM HUNT V KIZER POLICY AND PROCEDURES: APPLYING MEDICAL BILLS TOWARD SOC; OTHER PROVISIONS

I. DEFINITIONS

Beneficiary Notice (also called the Hunt Comprehensive Beneficiary Notice): This notice, the last of the series of Hunt informational notices to beneficiaries, is dated October 5, 1993 in the upper left hand corner, and is titled, "Your Rights To Use Old Medical Bills To Meet Your Share Of Cost."

Current Month: This refers to the current calendar month with respect to the reader. For example, the current month would be whatever month you are in when you read this. The current month changes each month.

Future Month: A future month is any month which is future to the current month.

Previous Month: A previous or past month is any month which occurred prior to the current month.

Current Medical Bills: The term "current medical bill" refers to a medical bill which is/was incurred in the same month (month of eligibility) for which it will be applied toward the beneficiary's SOC. As used in this ACWDL, the term "current medical bill" does not refer to the bill's chronological age. A medical bill incurred several months ago, and hence chronologically old, is nevertheless considered a current medical bill for the purpose of Hunt if the bill is applied by the beneficiary toward his/her SOC in the same month in which the bill was incurred.

Old Medical Bills: The term "old medical bill," as used in these Hunt Procedures, refers to a medical bill which was incurred in a month previous to the month for which it will be applied toward the beneficiary's SOC.

Old and current medical bills are treated differently under the terms of the Hunt settlement agreement. The most notable difference is that current medical bills may be applied toward SOC whether unpaid or paid without being subject to the conditions of the Hunt Paid Old Medical Bill Remedy or Hunt Retroactive Medi-Cal Card Remedy. Old medical bills applied toward SOC must be submitted to the county for processing. Some of the Hunt medical-bill qualifying criteria and verification requirements (Section III of this ACWDL, p. 14), and other requirements, are different for current and old medical bills.

Month In Which A Medical Bill Is Incurred: A medical bill is incurred on the date the medical service or drug is provided. The month in which a medical bill is incurred is the month in which this date of service falls.

Medical Bills Spanning Two Or More Months: In some instances, a medical bill will show a single medical expense for a medical service, such as a hospital stay, which was rendered over multiple days and therefore shows multiple dates of service. A medical bill showing such a multiple-day medical expense spanning more than one month is incurred in each month containing one or more dates of service for that expense. For example, a medical bill showing a single medical expense for a medical service, such as a hospital bed charge, might show the dates of service as March 27, 1992 through April 7, 1992. This medical expense has been incurred in both March and April.

When a medical bill spans two months, a portion of that bill is incurred in each month. If a beneficiary submits such a medical bill to the county, the county must determine how much of the bill was incurred in each month. To calculate the portion of the medical expense that was incurred in the first month the county should first calculate the daily charge for the medical

service by dividing the medical expense for that service by the number of dates of service for that expense, and then multiply the daily charge by the number of dates of service falling within the first month. Similarly the amount of the bill incurred in the second month is the daily charge multiplied by the number of days of service in the second month.

For example, suppose a beneficiary submits to the county for application toward his/her SOC for May 1992 a medical bill which was incurred over a two month period. The medical bill shows a charge of $400 for a four day stay in a hospital that began May 29, 1992 and ended June 1, 1992. (Assume the rest of the bill was paid by another person). If the hospital were to complete the MC 177 for this charge, it would be required to complete two MC 177s, one for May and one for June. If the beneficiary submits this medical bill to the county, the county must complete a MC 177 for May which shows only that portion of the medical bill which was incurred in May.

The portion of this bill incurred in May is found by first calculating the daily charge. The daily charge is $400 (the total amount billed to the beneficiary) divided by 4 (the number of days in the service period). The daily charge is then multiplied by 3 (the number of days of the service period falling in May) to obtain $300 as the amount billed to the beneficiary for May. This $300 is the portion of this bill which may be applied toward the beneficiary's May SOC. (The portion of the bill incurred in June is $100, the product of the $100 daily charge and the one date of service falling in June.)

These multiple-month medical bills may be applied toward SOC in the same way regular bills are. In the above example, if the beneficiary elects not to apply the May portion of the bill toward his/her May SOC, this May portion may be applied toward June's SOC if it meets the Hunt requirements. The June portion of the bill cannot be applied toward May's SOC because this portion of the bill did not exist in May.

Unpaid Old Medical Bills: Unpaid old medical bills are old medical bills which are unpaid at some time in the month in which they are submitted to the county (i.e. the old medical bills have not been paid previous to the month of their submission). If a portion of the old medical bill has been paid, the unpaid portion may still be applied toward the beneficiary's SOC.

Medical Bills and Medical Expenses: Medi-Cal can accept for application toward a beneficiary's SOC only medical bills for bona fide medical expenses. Expenses for medically-related services qualify as bona fide medical expenses if the service was rendered by a State-licensed health-care provider.

Expenses for medically-related equipment, supplies or drugs qualify as bona fide medical expenses if the equipment, supply-item or drug was:

1. Prescribed by a physician as necessary to treat a medical condition and;

2. Is customarily considered by the medical profession as primarily

for health care and medical treatment and;

3. Is intended, and will be used, solely for the health care and medical treatment of the beneficiary.

Medi-Cal presumes that medical expenses for drugs and supplies which are available only through a prescription are necessary to treat a medical condition and that expenses for these items are therefore bona fide medical expenses.

This presumption does not apply to medically-related equipment, drugs and supplies which a physician has prescribed but which are available without a prescription. For drugs, supplies, and medical equipment which have been prescribed, but which are available without a prescription, counties may require, at their discretion, that the beneficiary obtain a statement from the prescribing health-care provider attesting that each of the three above-numbered requirements are satisfied. The statement must include a short description of the condition being treated and must name the drug, supply, or medical equipment which the physician has prescribed.

If the county is uncertain whether the drug or other item is available without a prescription, the county may require that the beneficiary obtain a statement from the provider stating either that the item or drug is available only through a prescription, or attesting that each of the three above-numbered requirements are satisfied.

The county may disallow the application toward SOC of a medical expense for a drug or other item which is available without a prescription despite a provider's statement attesting to the three above-numbered items if the provider's statement is contrary to common sense. For example, a spa would not satisfy condition No. 2 above, despite the provider's statement that this condition is satisfied.

Remedy: The word "remedy" is used in this ACWDL to denote certain benefits belonging to the Medi-Cal beneficiary which have arisen as a result of the Hunt v Kizer lawsuit (Remedies are described in Section II of this ACWDL, p. 6.)

II. HUNT V KIZER REMEDIES: A) APPLYING OLD UNPAID MEDICAL EXPENSES (BILLS) TOWARD SOC; B) APPLYING OLD PAID MEDICAL BILLS TOWARD SOC; C) USING OLD MEDICAL BILLS TO OBTAIN A RETROACTIVE MEDICAL CARD; D) OPTIONAL REMEDY

A. Hunt v Kizer Standard Remedy: Applying Unpaid Old Medical Bills Toward Share of Cost. A Medi-Cal beneficiary may apply an old medical bill toward his/her SOC when all of the conditions below are satisfied.

1) The old medical bill, or the portion of the old medical bill, which will be applied toward SOC was unpaid at some time in the month

of its submission to the county (i.e. was not paid previous to the month of submission.) This condition is satisfied if the bill is unpaid at some time during the month of its submission (except where a bill was paid by the beneficiary in a previous month and then "refunded" by the provider in the month of its submission.)

2) The bill is not more than four years old as of the date of its submission. If the bill is more than four years old, it is subject to the Statute of Limitations, and not acceptable toward SOC, unless it falls under one of the exceptions to the Statute of Limitations. (See Section V of this ACWDL, p. 18.)

3) The old medical bill satisfies the qualifying criteria (Section III.A of this ACWDL, p. 14), verification requirements (Section III.B of this ACWDL, p. 15) and other applicable conditions discussed in this ACWDL.

Beneficiaries may also save and accumulate unpaid medical bills from a current month and then submit these bills as old medical bills toward their SOC in a later month. Old medical bills applied under this remedy to past month's SOC must have been incurred previous to the past month. These bills cannot be applied toward past months in which the beneficiary met his/her SOC and received a Medi-Cal card. These bills cannot be applied to months more than 12 months previous to the month of their submission (months for which a Letter of Authorization would be necessary) unless the beneficiary could qualify for a Letter of Authorization on grounds of administrative error.

B. Hunt v Kizer Paid Old Medical Bill Remedy; Applying Paid Old Medical Bills Toward SOC. The Hunt final settlement agreement allows Medi-Cal beneficiaries to apply certain old medical bills toward their SOC under the circumstances described in the numbered-paragraphs below. This remedy will be available to beneficiaries COMMENCING October 5, 1993, the date on the Hunt comprehensive beneficiary notice, and extending for a 6 month period, ending April 5, 1994. Old medical bills not submitted within this 6 month period may be applied toward SOC only under the Standard Remedy, and only if UNPAID.

To apply paid old medical bills toward SOC under the Paid Old Medical Bill Remedy, the individual must satisfy the following conditions:

1) The individual must have been a Medi-Cal beneficiary with a SOC as of October 5, 1993, the date on the Hunt comprehensive beneficiary notice.

The old medical bills which the individual wishes to apply toward his/her SOC under this remedy must satisfy all of the numbered conditions below:

2) The old medical bills were incurred no later than May, 1990;

3) The old medical bills were unpaid at anytime from July 1, 1988 through May, 1990 (i.e. the bills were not paid previous to July 1,

1988.) Old medical bills submitted under this remedy meet this requirement of being unpaid at sometime during this period if the bills are dated within this July, 1988 through May, 1990 period or if the dates of service shown on the bill are within this period. Old medical bills which bear a date previous to July 1, 1988 may have been paid previous to July 1, 1988 and would be unacceptable. To show that they were not previously paid, the beneficiary must provide reliable, valid documentation that the bill, or some portion of the bill, was unpaid at some time during this period. Such documentation may consist of a statement from the provider who issued the original bill, a collection agency statement, or other reliable, valid documentation. If the documentation is not on letterhead, or on a form identifying the entity issuing the documentation, it must be signed, initialed or signature-stamped by the issuing agency. Such documentation must be dated on or after July 1, 1988 to show the debt was not paid previous to July 1, 1988. The documentation must reference the bill. Portions of the bill which were paid previous to the retroactive period cannot be applied toward SOC.

4) The old medical bills are submitted to the county by April 5, 1994 (within 6 months of October 5, 1993 the date on the comprehensive beneficiary notice.)

5) The old medical bills satisfy the qualifying criteria (Section III.A of this ACWDL, p. 14), verification requirements (Section III.B of this ACWDL, p. 15), and other applicable conditions discussed in this ACWDL.

Current beneficiaries who satisfy the criteria above may utilize the Paid Old Medical Bill Remedy whether they were Medi-Cal beneficiaries during all or part of this period, from July, 1988 through May, 1990 or even if they were not beneficiaries for any part of this period. In addition, beneficiaries who were on Medi-Cal without a SOC in some months during this period, and then were either off Medi-Cal or were on Medi-Cal with a SOC in other months, may utilize this remedy if they have old medical bills which satisfy the numbered-conditions above.

The rationale for this paid-bill remedy is that certain individuals during this period, July 1, 1988 through May, 1990 had, but were not aware of, the right to apply old medical bills toward their SOC. Individuals who were not on Medi-Cal during this period were "harmed" because they might have elected to become Medi-Cal beneficiaries and applied these old medical bills toward their SOC had they known they could do so. Instead, they may have paid these old medical bills. Individuals who were on Medi-Cal with a SOC during this period were harmed because they too may have paid their old medical bills instead of applying them toward their SOC. Because these old medical bills may have been paid before the month of their submission, these individuals may be unable to use these old medical bills as unpaid old medical bills under the Standard Remedy.

C. Retroactive Medi-Cal Card Remedy; Using Old Medical Bills To Obtain A Retroactive Medical Card: The Hunt final settlement agreement allows specified individuals to apply certain PAID or UNPAID old medical bills

toward their SOC for certain past months in order to obtain a retroactive Medi-Cal card for those past months. This remedy will be available to individuals FOR A PERIOD OF 6 MONTHS, COMMENCING October 5, 1993, the date on the Hunt Comprehensive Beneficiary Notice, and ENDING April 5, 1994. Old medical bills not submitted within this 6 month period may be applied toward SOC only under the Standard Remedy, and only if UNPAID.

To obtain a retroactive Medi-Cal card under the retroactive remedy the individual must satisfy all of the numbered conditions below:

1) The individual was, as of October 5, 1993, the date on the Hunt comprehensive beneficiary notice, a Medi-Cal beneficiary who did not have a SOC OR who was not, as of this date, a Medi-Cal beneficiary.

2) The individual was a Medi-Cal beneficiary with a SOC in the past month, from July, 1988 through May, 1990 for which he/she wants a retroactive Medi-Cal card. Counties must examine all their pertinent Medi-Cal records for information regarding the individual's eligibility and SOC status during the July, 1988 through May, 1990 period. If the county cannot find any record evincing the individual's eligibility during this period, the individual must submit written documentation that he/she was on Medi-Cal with SOC during the above-mentioned period. This documentation may consist of a SOC form containing a county entry of the beneficiary's name and SOC amount, or any other written notice from the county showing that the person was on Medi-Cal with a SOC during this period. If the county can find only a truncated MEDS or other county record which shows that the individual was a beneficiary at sometime during this period but which, due to the records truncation, does not indicate whether the individual had a SOC, the individual may sign a sworn statement attesting that he/she had a SOC during this time, and attesting to the amount of this SOC. A sworn statement is not otherwise acceptable.

3) The individual incurred medical bills in the past month for which he/she wants a retroactive Medi-Cal Card. The individual must submit these medical bills to the county. As these are the medical bills which the beneficiary wants Medi-Cal to pay for, counties must not process these bills with the old medical bills the beneficiary is submitting for application toward his/her SOC in the retroactive month unless the beneficiary must utilize some of these medical bills in order to meet his/her SOC for the retroactive month.

The paid or unpaid old medical bills which the individual wishes to apply toward his/her SOC for purposes of obtaining a retroactive Medi-Cal card must satisfy all of the following:

4) The currently paid or unpaid medical bills will be applied toward the individual's SOC for a past month(s) from July, 1988 through May 1990, in which the individual was on Medi-Cal;

5) All or some of the medical bills which will be applied toward the beneficiary's SOC in the past month (retroactive month) for which the beneficiary wants a retroactive Medi-Cal card, were incurred

previous to the retroactive month (some of these old medical bills may have been incurred in the retroactive month.) All such old medical bills must have been unpaid at some time in the retroactive month (they must not have been paid previous to the retroactive month.) Medi-Cal deems that an old medical bill whose dates of service indicate that the bill was incurred previous to the retroactive month, but which bill was dated within the retroactive month or later, indicating that it was re-issued during this month or later, satisfies the requirement that the bill was unpaid at some time during the retroactive month and was not paid previous to the retroactive month. If an old medical bill is dated previous to the retroactive month, the beneficiary must provide reliable, valid documentation that the bill, or some portion of the bill, was unpaid at some time during this period. Such documentation may consist of a statement from the provider who issued the original bill, a collection agency statement, or other reliable, valid documentation. If the documentation is not on letterhead, or on a form identifying the entity issuing the documentation, it must be signed, initialed or signature-stamped by the issuing agency.

6) These paid or unpaid old medical bills, described in numbered-paragraph 5, above, completely meet the SOC for the retroactive month, either alone or in combination with unused medical bills incurred by the beneficiary during the retroactive month.

7) The medical bills described in numbered-paragraph 6, above, are submitted to the county by April 5, 1994 (within 6 months of the date on the Hunt comprehensive beneficiary notice.)

8) The medical bills submitted under this remedy satisfy the qualifying criteria (Section III.A of this ACWDL, p. 14), verification requirements (Section III.B of this ACWDL, p. 15), and other applicable conditions discussed in this ACWDL.

The function of a Medi-Cal card issued for one of these past months is to enable providers to bill Medi-Cal for medical services billed to the beneficiary in that past month. Once the provider has received payment from Medi-Cal for the service(s), he/she must in turn pay the beneficiary for the full amount actually paid by the beneficiary for that service(s). If the beneficiary has only partly paid for the service(s), any of the beneficiary's payments to the provider must be reimbursed by the provider, and any of the beneficiary's remaining indebtedness for the service(s) must be canceled. Upon receiving Medi-Cal payment, the provider must cancel the full amount of any debt owed by the beneficiary who has not made any payment for the service.

For example, an individual who satisfies the criteria for the Retroactive Medi-Cal Card Remedy submits sufficient qualifying medical bills incurred previous to July, 1988 to fully meet his/her $400 SOC for July, 1988. He/she had incurred $300 in medical expenses in July, 1988 of which $200 had been previously paid by him/her and $100 was still owed. All the providers who rendered him/her the services comprising the $300 worth of July bills may now bill Medi-Cal for these services if not previously billed to Medi-Cal. Suppose one provider provided the entire $300 worth of services. Suppose

under the Medi-Cal rate the provider receives $150 from Medi-Cal as payment for these services. The provider is nevertheless obligated to refund to the beneficiary the $200 he/she actually paid, and the provider must also cancel the individual's remaining indebtedness of $100. In an example identical to the one above except that the individual had made no payments on the $300 worth of services, the provider would be obligated only to cancel the individual's $300 indebtedness after receiving payment from Medi-Cal.

The purpose of this Retroactive Medi-Cal Card Remedy is to compensate individuals who were Medi-Cal beneficiaries during this July, 1988 through May, 1990 period and who should have been permitted to apply their previously incurred old medical bills toward their SOC during this period, but who were not so permitted because at this time Medi-Cal did not accept old medical bills. These individuals are entitled to a retroactive Medi-Cal card instead of applying these old medical bills toward their current or future SOC because these individuals could not, as of the date on the Comprehensive Beneficiary Notice, apply these old medical bills toward their current or future month's SOC as they were not beneficiaries with a SOC at that time. Beneficiaries may now apply these medical bills (from numbered-paragraph 6, above) toward their SOC for months within the retroactive period that they designate. Beneficiaries may then be reimbursed for medical bills incurred in the designated retroactive months which are no longer needed to meet the beneficiary's SOC.

C(i). Procedures For Issuing Retroactive Medi-Cal Cards Under The Hunt Retroactive Remedy: Counties will need the following forms: MC 177, MC 1054 HK (attached as Exhibit A), and a "Letter of Authorization (attached as Exhibit A)."

MC 177: While for the other Hunt remedies counties may process medical bills either by completing a MC 177 or by "adjusting SOC" on MEDS (see Section IX.C of this ACWDL, p. 25), for the Hunt Retroactive Medi-Cal Card remedy, counties must complete a MC 177. The primary purpose of the MC 177 is to indicate to providers which medical bills submitted under this remedy were used to meet the beneficiary's SOC in the retroactive month so that the providers will know which bills cannot be billed to Medi-Cal and for which the beneficiary cannot be reimbursed. DO NOT send a copy of the MC 177 completed under this remedy to the Department of Health Services. DO keep a copy in the case file.

The county should examine the beneficiary's medical bills submitted under this remedy to ensure that the beneficiary has sufficient qualifying medical bills to meet his/her SOC for the month (retroactive month) for which the beneficiary wishes to obtain a retroactive Medi-Cal card. The beneficiary may submit either old medical bills incurred previous to the retroactive month or medical bills incurred in the retroactive month. The county must then complete an MC 177 for the retroactive month, transferring billing information from the medical bills submitted by the beneficiary into the appropriate blocks of the MC 177. Billing information from old medical bills incurred previous to the retroactive month should be entered onto the MC 177 before entering information from bills incurred in the retroactive month. For the last bill entered onto the MC 177, which will meet or exceed the beneficiary's SOC, enter in the "Billed Patient" block the amount

necessary to meet the beneficiary's SOC, and then write the total amount of the bill in the "Total Bill" block.

The county will issue a legible copy of the completed MC 177 to the beneficiary and instruct him/her that his/her provider must receive this form before the provider can participate in this remedy. A separate MC 177 copy must be issued for each provider from whom the beneficiary wishes reimbursement. Where the beneficiary wishes reimbursement for several months within the retroactive period from the same provider, a separate MC 177 for each month is needed for that provider. (DO NOT send a copy of MC 177s issued under this remedy to the Department of Health Services. DO keep a copy in the case file.)

MC 1054 HK (Exhibit A): This form, a modification of the MC 1054, will advise the provider of his/her obligations to participate in this remedy, and will inform him/her of the correct procedure for billing Medi-Cal under this remedy. The county should complete and issue this form to the beneficiary, and instruct the beneficiary that this form must be submitted to the provider before he/she can participate in this remedy. A separate MC 1054 HK must be issued for each provider from whom the beneficiary wishes reimbursement. Where the beneficiary wishes reimbursement for several months within this period from the same provider, only one MC 1054 HK is needed for that provider.

"Letter of Authorization (Exhibit A):" When a beneficiary qualifies for a retroactive Medi-Cal card under the Hunt Retroactive Remedy, the county must follow the procedures outlined in chapter 14E of the Medi-Cal Eligibility Manual Procedures, titled, "Issuance of Medi-Cal Cards More Than One Year After The Date Of Service."

These procedures must be followed because retroactive Medi-Cal cards issued under this remedy will exceed the 12 month limitation on issuance of retroactive Medi-Cal cards established by Section 50746 of Title 22 of the California Code of Regulations. Per these procedures, the county will issue to the beneficiary a "Letter of Authorization" (Authorization Letter) and a retroactive Medi-Cal card with Proof of Eligibility labels.

The county should inform the beneficiary that he/she is responsible for ensuring that the provider from whom he/she wants reimbursement receives the "Letter of Authorization." This Authorization Letter, and a Proof of Eligibility (POE) label, must accompany each provider's claim to Medi-Cal for payment of the services for which the beneficiary wants reimbursement under this Retroactive Medi-Cal Card Remedy. A separate Authorization Letter must be issued for each provider from whom the beneficiary wishes reimbursement. Where the beneficiary wishes reimbursement for several months within this period from the same provider, only one Authorization Letter is needed for that provider.

The county will complete the Authorization Letter per instructions in revised chapter 14E of the Medi-Cal Eligibility Manual Procedures. The county should indicate on this form that the retroactive Medi-Cal card is being issued pursuant to a court order by checking the appropriate line on the form. The county must also identify the lawsuit requiring the issuance of the retroactive Medi-Card by writing on the "checked" line the words:

"Hunt v Kizer" (see sample form, Exhibit A.)

The beneficiary must take the MC 177, MC 1054 HK, Authorization Letter and retroactive Medi-Cal card to the provider from whom the beneficiary desires reimbursement or debt-cancellation. The beneficiary should request the provider to bill Medi-Cal for medical services which the provider previously had billed to the beneficiary.

Providers who were enrolled as Medi-Cal providers at the time they rendered the service to the individual may bill Medi-Cal regardless of whether they are still Medi-Cal providers. Providers who were not enrolled as Medi-Cal providers at the time they rendered the service cannot bill Medi-Cal for the service.

The provider should not bill Medi-Cal for services which are not covered by Medi-Cal. Medi-Cal will not pay for such services. However, the provider may bill Medi-Cal under this remedy for medical services which would normally require approval of a "Treatment Authorization Request" (TAR) or a "MEDI" label without obtaining either of these items. Medi-Cal waives the TAR and "MEDI" label requirement for provider claims submitted under this remedy.

D. Optional Remedy: Alternative to Retroactive Medi-Cal Card Remedy For Beneficiaries Eligible For The Retroactive Remedy: The Settlement Agreement provides another benefit which certain individuals may qualify for. This benefit, called the Optional Remedy, allows these individuals to apply certain old medical bills toward their SOC whether the old medical bills are paid or unpaid as of the date they are submitted. The criteria which must be met in order to qualify for this remedy are set forth below.

1) The individual was, as of October 5, 1993 the date on the Hunt comprehensive beneficiary notice, a Medi-Cal beneficiary who did not have a SOC OR who was not, as of this date, a Medi-Cal beneficiary.

2) The individual must become a Medi-Cal beneficiary with a SOC by April 5, 1994.

3) The individual was a Medi-Cal beneficiary with a SOC in one or more months during the period July, 1988 through May, 1990. Counties must examine all their pertinent Medi-Cal records for information regarding the individual's eligibility and SOC status during the July, 1988 through May, 1990 period. If the county cannot find any record evincing the individual's eligibility during this period, the individual must submit written documentation that he/she were on Medi-Cal with SOC during the above-mentioned period. This documentation may consist of a SOC form containing a county entry of the beneficiary's name and SOC amount, or any other written notice from the county showing that the person was on Medi-Cal with a SOC during this period. If the county can find only a truncated MEDS or other county record which shows that the individual was a beneficiary at sometime during this period but which, due do the records truncation, does not indicate whether the individual had a SOC, the

individual may sign a sworn statement attesting that he/she had a SOC during this time, and attesting to the amount of this SOC. A sworn statement is not otherwise acceptable.

The PAID or unpaid old medical bills which the individual wishes to submit under the Optional Remedy for application toward his/her SOC must satisfy all of the following:

5) The old medical bills submitted under this remedy were incurred previous to May 31, 1990 and were unpaid at some time during the July 1, 1988 through May 31, 1990 period and would have met the beneficiary's SOC in one of the months in this period for which these old medical bills would have qualified for application toward SOC.

6) The medical bills submitted under this remedy must be submitted to the county between October 5, 1993 and April 5, 1994, inclusive. Medical bills not submitted within this 6 month period may be applied toward SOC only under the Standard Remedy, and only if UNPAID.

7) The medical bills submitted under this remedy must satisfy the , qualifying criteria (Section III.A of this ACWDL, p. 14), verification requirements (Section III.B of this ACWDL, p. 15), and other applicable conditions discussed in this ACWDL.

Old medical bills submitted for application toward SOC under this remedy (or any Hunt remedy) must not have previously been applied toward SOC and must not have been an expense which the provider has indicated he/she will bill to Medi-Cal.

III. QUALIFYING CRITERIA AND VERIFICATION REQUIREMENTS FOR CURRENT AND OLD MEDICAL BILLS

A. Qualifying Criteria: This Section lists the criteria which a medical bill must satisfy before it can be applied toward SOC. All the below criteria (Nos. 1-6) apply to UNPAID OLD medical bills submitted under the Hunt "Standard Remedy"; only criteria 3-6 apply to PAID (or unpaid) OLD medical bills submitted under the Hunt "Paid Old Medical Bill Remedy", "Retroactive Medi-Cal Card Remedy" and "Optional Remedy". Only criteria 3-6 apply to CURRENT medical bills.

1) The old medical bill must be unpaid at some time in the month of the bill's submission to the county (i.e. the bill must not have been paid previous to the month in which it is submitted). To ease administration, the county may consider this requirement satisfied when the bill's date of issuance falls within 90 days of the bill's submission to the county (see also Section III.B.7 of this ACWDL, p. 16), unless the beneficiary indicates that the bill has been paid or the county has reason to believe that the bill has been paid since the bill's issuance date.

2) The old medical bill is less than four years old as of the date of the bill's submission, with certain exceptions (see Statute of Limitations, Section V of this ACWDL, p. 18.)

3) That portion of the old or current medical bill for which a third party is liable must first be subtracted from the amount billed to the beneficiary.

4) The portion of a current or old medical bill previously used to meet Medi-Cal SOC may not be re-applied toward SOC.

5) The current or old medical bill must be an original bill, an authenticated copy, or an acceptable substitute (see Section VI of this ACWDL, p. 19);

6) The current or old medical bill must satisfy the list of verification requirements discussed in this Section, see below.

Unpaid old medical bills applied toward SOC under the Hunt "Standard Remedy" (Section II, p.6) are not acceptable if completely paid previous to the month of their submission. If partly paid previous to the month of their submission, only the portion remaining unpaid in the month of submission can be applied toward SOC.

The Hunt "Paid Old Medical Bill Remedy" and "Retroactive Remedy" permit old medical bills to be applied toward SOC even though such bills were paid before being submitted to the county and even though such bills may be more than 4 years old. Medical bills applied toward SOC as current medical bills may be paid or unpaid.

B. Verification Requirements For Current And Old Medical Bills: Current and old medical bills applied towards a beneficiary's SOC must contain certain items of information . These items are called the medical bill's "verification" requirements. These verification requirements assure that submitted medical bills are accurate and valid. They apply both to current medical bills and to old medical bills, except where noted. The verification requirements which must be satisfied are:

1) The medical bill must show the name and address of the provider who provided the service.

2) The medical bill must show the name of person who received the medical service.

3) The medical bill must contain a short description of the medical service received.

4) The medical bill must show a "Procedure Code" (a medical reference number) unless the bill was both incurred before January 1, 1992 and applied toward SOC as an old medical bill (see Definitions, Section I), in which case the bill is acceptable without a procedure code. For all medical bills applied toward SOC as current medical bills (see Definitions, Section I) and for all medical bills incurred after

January 1, 1992 regardless of whether such medical bills are applied toward the beneficiary's SOC as current medical bills or old medical bills, a procedure code must be shown on the bill.

5) The medical bill must show either the provider's Medi-Cal provider identification number, taxpayer identification number, or provider license number.

6) The medical bill must show the date(s) the medical service was provided.

7) The medical bill must show the date on which the bill was issued. For unpaid old medical bills submitted toward SOC under the Standard Remedy (Section II.A of this ACWDL, p. 6), the billing date must be within 90 days of the date the bill is received by the county. This 90-day requirement does not apply to old medical bills submitted toward SOC in a current or future month under the Paid Old Medical Bill Remedy, nor to old medical bills submitted to obtain a retroactive Medi-Cal card under the Retroactive Medi-Cal Card Remedy, nor to bills submitted under the Optional Remedy. Such bills need not be dated within 90 days of their submission to the county.

8) The medical bill must show the amount owed solely by the beneficiary and not subject to third party coverage. If the beneficiary has other health care coverage, the amount billed solely to the beneficiary may be demonstrated by a bill which shows the total amount of the bill and a separate amount billed to the beneficiary. If the beneficiary has other health care coverage, and the bill does not show the total amount billed for the service, and a separate amount billed to the beneficiary, the county may require that the beneficiary obtain a statement from his/her provider or health insurer showing the total amount for the service and the amount for which the beneficiary is solely liable. A statement from the beneficiary's health insurer may include either a statement showing how much the insurer will pay or a check or pay stub from the insurer which properly references the medical service paid for and which shows how much the insurer paid. If the beneficiary does not have other health care coverage, the county may treat the total billed amount as the amount owed solely by the beneficiary.

Note that the verification requirements are not identical for all medical bills. Whether a procedure code is required depends on when the bill was incurred and whether it is an old medical bill --see item No. 4 above. The requirement that a medical bill submitted for application toward SOC be dated within 90 days of the bill's submission --see item No. 7 above-- is not applicable to all medical bills. Submitted medical bills should be carefully evaluated to determine whether a procedure code is necessary and whether the bill must be dated within 90 days of its submission.

Some of the numbered verification requirements listed above may be supplied by the beneficiary in a sworn statement (Section VII of this ACWDL, p. 21) if they are missing from the medical bill. When an old medical bill fails to meet the qualifying criteria, verification requirements, or other requirements discussed in this ACWDL, and the beneficiary is unable to cure

the deficiency in a manner consistent with the procedures delineated within this ACWDL, the county must reject the medical bill following the procedures in Section VIII of this ACWDL, p. 23.

IV. LIMITATIONS ON USE OF MEDICAL BILLS APPLIED TOWARD SOC UNDER THE STANDARD REMEDY, PAID OLD MEDICAL BILL REMEDY, AND OPTIONAL REMEDY

A. Old Medical Bills Submitted Under The Standard Remedy, Paid Old Medical Bill Remedy, and Optional Remedy, May Be Used In Past Months And The Next Month With Certain Limitations: Beneficiaries do not have the right to submit an old medical bill and designate a month several months in the future as the month in which their old medical bill is to be applied toward their SOC. If the beneficiary wants to apply an old medical bill toward his/her SOC in a future month, the county may require the beneficiary to submit the old medical bill in that future month. At its discretion, the county may accept old medical bills for application toward SOC one month in advance.

Beneficiaries may apply these old medical bills toward a past month's SOC. Such bills must have been incurred previous to that past month. These bills cannot be applied toward those past months in which the beneficiary met his/her SOC and received a Medi-Cal card. These bills cannot be applied to months more than 12 months previous to the month of their submission (months for which a Letter of Authorization would be necessary.) unless the beneficiary would qualify for a Letter of Authorization on the ground of administrative error.

The county should presume that the beneficiary intends to apply an old medical bill in the month in which he/she submits it, unless he/she indicates otherwise. In order to avoid misunderstanding, and potential disputes, the county may require a beneficiary to submit written identification of the past month in which the beneficiary wishes to apply the old medical bill toward his/her SOC. The county may also require written statement from the beneficiary if he/she wishes to apply the old medical bill in the month after the month of submission.

B. Old Medical Bills Applied to Consecutive Months SOC Commencing With Month Of Submission: An old medical bill submitted for application toward SOC, which exceeds the beneficiary's SOC for the month in which it is being applied toward his/her SOC, must continue to be applied toward the beneficiary's/MFBU's/individual's SOC in consecutive months starting with the month after the bill's submission until the sum of the monthly SOC amounts to which the bill has been applied equals the unpaid amount on the old medical bill which was billed to the beneficiary. Otherwise, large numbers of partially used old medical bills may accumulate in county Medi-Cal case files. Maintaining records on the amounts of each bill not applied toward SOC, and re-evaluation of such bills to assess whether any portion of the bill had been paid since the bill was last used to meet SOC would be

extremely time consuming, costly, and complex, and the inevitable misunderstanding between beneficiaries and counties would result in frequent disputes.

Some of these consecutive months may fall outside the 6 month period for which certain of the above remedies are effective. This is acceptable. If a beneficiary is discontinued from Medi-Cal he/she may not apply, in the event he/she again becomes a Medi-Cal beneficiary with a SOC, the remaining, unapplied balance of any old medical bill previously applied toward his/her SOC under the Paid Old Medical Bill Remedy or Optional Remedy but may apply these old medical bills under the Standard Remedy.

C. Prioritizing Old Medical Bills For Application Toward SOC: Although Medi-Cal pays for a very broad range of medical services (covered medical expenses), the beneficiary may submit a medical expense for a medical service which was rendered by a provider who is not a Medi-Cal provider. These kinds of medical services are called non-covered medical services. Although they are non-covered services, they are medical services and may be applied toward SOC.

If the beneficiary submits multiple medical bills for application toward SOC, and if these medical bills exceed the SOC, counties should advise beneficiaries to select bills for uncovered medical expenses for application toward SOC before selecting covered services. Individuals who seek medical care as Medi-Cal beneficiaries are expected to identify themselves to the provider as Medi-Cal beneficiaries and to inquire with the provider as to whether he/she is a Medi-Cal provider and whether he/she can bill the service to Medi-Cal. The beneficiary who submits medical expenses should therefore know whether the expense is uncovered.

V. STATUTE OF LIMITATIONS FOR OLD MEDICAL BILLS

For old medical bills submitted under the Hunt Standard Remedy, only that portion of an old medical bill not paid previous to the month of submission, and for which the beneficiary is still legally liable, may be applied toward SOC. If a medical bill is more than 4 years old, measured from the date of submission, it is presumptively voidable under the applicable Statute of Limitations in California law, and the beneficiary is not legally liable for such a bill. Counties must disapprove these bills, unless the beneficiary can demonstrate that his/her medical bill falls into one of the exceptions to the Statute of Limitations. These exceptions are listed below.

1) The medical expenses has been reduced to judgment in a formal judicial proceeding.

2) There is a contract between the provider of the service and the recipient of the service extending the statute of limitation beyond four years and the bill falls within the contract period.

3) The beneficiary has made a payment on the bill within the last four years.

4) There is other reasonable written verification showing the person is still liable for the expense.

VI. SUBSTITUTE MEDICAL BILLS AND OTHER SUPPORTING DOCUMENTATION FOR MISSING VERIFICATION ITEMS

A. Kinds of Medical Expense Statements Which May "Substitute" For The Health-Care Providers Medical Bill: Generally medical bills submitted toward SOC must be formal heath-care provider billing statements or invoices. This ACWDL will call these provider billing statements or invoices "conventional" billing statements. In addition, pursuant to the terms of the Hunt Settlement Agreement, Medi-Cal will also accept as medical bills certain alternative billing statements in place of the provider billing statement. These alternatives, called "substitute billing statements," may be credit card billing statements, collection agency billing statements, and other written billing statements by a provider. Before one of these substitute billing statements may be applied toward SOC, they must meet all applicable qualifying criteria (Section III.A of this ACWDL, p. 14), verification requirements (Section III.B of this ACWDL, p. 15), and other applicable standards (e.g. originality requirement) delineated in this ACWDL. Qualifying substitute billing statements may be applied toward SOC even though unaccompanied by a conventional provider invoice or billing statement.

B. Credit Card Statements Used As Substitute Medical Bills: When a beneficiary wishes to apply a credit card billing statement which shows a medical expense as a substitute unpaid medical bill toward his/her SOC under the Standard Remedy, he/she must, in addition to satisfying the qualifying criteria, verification and other requirements, demonstrate that the charged medical expense has not been paid previous to the month of submission of the bill. To demonstrate this, the beneficiary must provide credit card statements to the county for every month beginning with the month in which the medical expense was incurred through the month previous to the one in which the credit card statement was submitted to the county. These statements must show that no payments have been made on the charge-card account since the medical expense was incurred.

If any of these subsequent credit-card statements reveal payments made to the charge-card account, the amount of the charged medical expense which may be applied toward SOC must be reduced by a amount commensurate to the amount of the subsequent payment(s). If the beneficiary is unable to provide all of the credit card statements necessary to show his/her payment record since the date of the credit card statement showing the charged medical expense, the county cannot accept the credit card billing statement for application toward the beneficiary's SOC.

For credit card billing statements showing medical expenses submitted toward SOC under the Paid Old Medical Bill Remedy, the beneficiary may submit a

credit card billing statement dated between July, 1988 through May, 1990 (retroactive period) which shows the charged medical expense. When the credit card billing statement showing the charged medical expense is dated within the retroactive period, the beneficiary need not submit any subsequent credit card statements as it is not necessary for the beneficiary to prove he made no later payments on the credit card. If the credit card billing statement showing the charged medical expense is dated previous to the retroactive period, the beneficiary must demonstrate that he/she has made no payments on that card between the date of the charged medical expense and July, 1988. The beneficiary may do this by submitting to the county credit card statements for all months between the month in which the medical expense was charged, and July, 1988. If the beneficiary is unable to provide any of the required credit card statements, the county cannot accept the credit card billing statements for application toward SOC. Any payments made on the card must be subtracted from the charged medical bill before it is applied toward SOC.

For credit card billing statements submitted toward SOC under the Retroactive Medi-Cal Card Remedy, the beneficiary may submit a credit card statement which shows a charged medical expense and is dated for a month previous to the month (retroactive month) for which he/she wants a retroactive Medi-Cal card, or is dated within the retroactive month. For credit card statements dated within the retroactive month, the beneficiary need not submit any additional credit card statements to prove no subsequent payments on the charge were made as such medical bills may be applied toward SOC under this remedy even though paid in the month they were incurred. For credit card statements dated previous to the retroactive month the beneficiary must demonstrate that he/she made no payments on the credit card previous to the month for which the retroactive Medi-Cal card is sought. The beneficiary must demonstrate this by submitting credit card statements for all months between the month in which the medical expense was charged and the month for which the retroactive Medi-Cal card is sought. If the beneficiary is unable to provide any of the required credit card statements, the county cannot accept the credit card billing statements for application toward SOC. Any payments made on the card previous to the retroactive month must be subtracted from the charged medical bill before it is applied toward SOC.

Credit card statements applied toward SOC as substitute medical bills need not be dated within 90 days of the submission of the bill (Section III.B.7 of this ACWDL, p. 16), nor does the beneficiary need to obtain a statement from the provider stating that the bill is still unpaid. The beneficiary, by demonstrating that he/she has made no subsequent payments on the charged medical expense, accomplishes the purposes of these two conditions.

Interest charged by the credit card company on a charged medical expense cannot be applied toward SOC.

C. Alternative Billing Statements Which Fail To Qualify As Substitute Medical Bills: When an alternative billing statement fails to qualify as a substitute medical bill, it cannot, by itself, be applied toward SOC. But such alternative billings statements may still be submitted toward SOC in combination with a conventional provider billing statement or invoice in order to supply information missing from the conventional billing statement

or invoice. For example, a conventional invoice which cannot be accepted for application toward SOC because certain verification information, such as the billing date, or amount separately billed to the beneficiary, is missing, may be rendered acceptable if accompanied by a credit card or collection agency statement containing the missing information. Alternative billing statements may be used to update the conventional statement in order to meet the 90-day verification requirement.

Before accepting a substitute billing statement submitted for the purpose of augmenting a provider billing statement, the county must determine that the substitute bill is a valid billing statement and that it is a bill for the same service as the conventional provider billing statement or invoice which it augments.

D. Other Supplemental Documentation For Medical Bills Missing Verification Items: A conventional provider billing statement may be supplemented with original supporting documentation such as a handwritten note, signed or initialed by the provider, which provides the verification items missing from the billing statement. Such supplemental documentation cannot be submitted in place of the conventional provider billing statement.

E. Original Medical Billing Statements verses Photocopies: All medical bills, including substitute medical bills, submitted by the beneficiary to the county for application toward the beneficiary's SOC must either be original billing statements, or if photocopies, must be signed, initialed, or signature-stamped by the provider. If not signed, initialed, or signature-stamped by the provider, a medical-bill photocopy may still be acceptable for application toward SOC if there is other, original supporting documentation that corroborates the validity and accuracy of the bill. For example, such corroborative evidence could be a statement from the provider that the bill photocopy is a valid bill and the amount billed to the beneficiary is owed solely by the beneficiary. Such corroborative statements must properly reference the billing statement.

Credit card or collection agency statements must either be original statements or, if copies, be signed, initialed or signature-stamped by the manager of the account and this person must have legal authority to represent the billing organization. Conventional or substitute medical bills which have been altered are unacceptable except that provider billing statements updated by the provider are acceptable when the provider has signed or initialed the notation which updates the billing statement.

VII. BENEFICIARY'S AND COUNTY'S OBLIGATION TO OBTAIN VERIFICATION INFORMATION; BENEFICIARY'S SWORN STATEMENT

A. Beneficiary's Obligation To Obtain Verification Information: Medical bills submitted to the county to meet SOC must satisfy the qualifying criteria and verification requirements (Section III of this ACWDL, p. 14) and any other applicable requirements before they can be accepted by the county. The beneficiary is under the obligation to make an effort to obtain

verification information missing from the medical bill. The beneficiary has made an effort when he/she has contacted the provider and requested a new bill, acceptable photocopy (see Section VI.E of this ACWDL, p. 21), or other acceptable documentation, such as a note from the provider, which contains the missing verification items. Beneficiaries may be required to sign an affidavit stating that they have made such an effort.

When a beneficiary is mentally incapacitated, or comatose, the beneficiary's representative, a conservator, spouse, or other relative, must act on the beneficiary's behalf, and make an effort to obtain verification information missing from old medical bills (see 22 CCR 50163). If such a beneficiary does not have a representative, the county is obligated to assist in obtaining the necessary verification information, see paragraph below.

B. County's Obligation To Assist Beneficiaries In Obtaining Verification Information: If the beneficiary submits a medical bill to the county but has been unable to obtain all the required verification items after having made an effort to do so, the county must assist in obtaining the information. A county's assistance may consist of a phone call or letter to a provider requesting that the provider, verbally or in writing, provide the county with the necessary information. A county's duty to assist is predicated upon the beneficiary providing an original old medical bill from the provider or a (non-photocopied) acceptable substitute bill. A piece of paper which has no identifying information is not a medical bill. Copies from bookkeeping records are not medical bills. The county may require the beneficiary to furnish the provider's name and telephone number, if these are missing from the medical bill, as prerequisites to the county's assistance in obtaining missing verification information. The county is not required to obtain a medical bill for a beneficiary who claims to have a medical expense but has no medical bill.

When a county obtains verification information needed for a bill from a provider by telephone, the county should note that information on the old medical bill and the eligibility worker noting the information should initial the entry. Approved old medical bills should be kept in the case file.

C. Beneficiaries Sworn Statement: If the beneficiary has made an effort to obtain the missing verification requirements but was unable to do so, and the county was unable to obtain the missing information, the beneficiary may make a written, sworn statement attesting to certain of the verification items. Beneficiaries may attest to verification requirements numbered 1 through 6 in Section III.B of this ACWDL, p. 15. Beneficiaries may not attest to verification requirement No. 7, "the date the bill was issued", and verification requirement No. 8, the amount of the bill owed solely by the beneficiary. In those instances where the beneficiary alleges that the date of service for a bill is in the same past month for which he/she wants to apply the medical bills toward SOC, and this date of service does not correspond to the date of the bill, the beneficiary may not attest to this date because it is also the billing date. When the beneficiary may not attest to a verification requirement, he/she must provide verification in the form of an original bill, a signed, initialed or signature-stamped photocopy, or a provider's statement which shows the required information.

The county must determine that the beneficiary has knowledge of the information to which he/she attests. This is especially true when the beneficiary attests to the provider's identification number, the procedure code, or the type of service.

VIII. ACCEPTING AND REJECTING MEDICAL BILLS; HUNT NOTICES: "HUNT FIRST DISAPPROVAL LETTER", "HUNT SECOND DISAPPROVAL LETTER," "HUNT MEDICAL BILLS APPROVED LETTER"

A. Rejecting and Accepting Medical Bills For Application Toward A Beneficiary's SOC: A medical bill submitted by the beneficiary may be rejected by the county because it fails to meet one or more of the criteria or requirements enumerated in this ACWDL or because the bill, in combination with the other bills submitted by the beneficiary, fail to meet the beneficiary's SOC. All rejected medical bills must be returned to the beneficiary. The beneficiary is responsible for keeping these returned bills if the beneficiary wishes to re-submit them at a later date. The beneficiary may re-submit returned bills when he/she has corrected the problem which caused the bills to be rejected. Counties should keep copies of the rejected medical bills. Copies, or ledgers, of bills rejected only because insufficient qualifying medical bills were submitted to meet SOC, might expedite the process of re-evaluating these bills in the event the beneficiary re-submits them at a later date.

Medical bills submitted by the beneficiary are acceptable for application toward the beneficiary's SOC only when such bills meet all the qualifying criteria and verification requirements of these Procedures, and completely meet the beneficiary's SOC for the month in which the bills were submitted. If the bills are not acceptable, the county must reject the bills. If the bills are acceptable, counties must keep the original of all bills submitted by the beneficiary. If the county processes a bill by submitting an MC 177 to the State (see also Section IX.C of this ACWDL, p. 25), a copy of the bill must accompany the MC 177 and the county should keep the original bill for its files. If the county processes the medical bill by using the MEDS system (see p. 27 of this ACWDL), the county will keep the original bill in its files and will make a copy of the bill for the beneficiary.

When an old medical bill has been previously submitted by the beneficiary and rejected by the county, it may be re-submitted. In such cases, the old medical bill is evaluated for application toward SOC in the month in which it is resubmitted, and not the earlier month of submission, except when the bill has been re-submitted within the 10 day period allowed by the Hunt First Disapproval Letter (see below) or when the medical bill has been re-submitted for application toward SOC in the past month in which the bill was incurred in accordance with 22 CFR Section 50746.

B. Hunt Notices (Approval Letter, First Disapproval Letter, and Second Disapproval Letter): After the county has rejected or accepted the medical

bills submitted for application toward SOC, the county is required to notify the beneficiary by issuing the appropriate form letter(s)/notices (discussed below and attached as Exhibit A). The county is not required to complete and distribute these forms when the medical expenses which the beneficiary wants to apply to his/her SOC for the month have been recorded by the provider on the MC 177.

C. Hunt Notice For Accepted Medical Bills (Hunt Approval Letter): When the county has determined that a medical bill is acceptable for application toward the beneficiary's SOC, the county shall complete and send to the beneficiary a Hunt v. Kizer "Medical Bills Approved Letter" (Approval Letter). A copy of this Approval Letter is attached as Exhibit A. This Approval Letter should be sent within 30 days of the beneficiary's submission of the approved bills. The county must keep copies of these Approval Letters for its files.

D. "Hunt First Disapproval Letter": When the county rejects a medical bill submitted by the beneficiary for application toward his/her SOC, the county must inform the beneficiary of the reason for the rejection, and return the rejected bill to the beneficiary. The beneficiary must then correct the problem before re-submitting the bill.

The county must document rejected medical bills by completing and issuing a "Hunt First Disapproval Letter" (First Disapproval Letter) (attached as Exhibit A) to the beneficiary. This First Disapproval Letter will inform the beneficiary which medical bills were rejected and indicate for each rejected bill the reason for its rejection. The beneficiary may resubmit the bill once the reason which caused its rejection is corrected. This First Disapproval Letter must be issued within 10 days of the beneficiary's submission of the disapproved medical bills. The county must keep a copy of each First Disapproval Letter which it issues.

To complete this First Disapproval Letter, enter the name of the billing provider, the billing date, and the amount of the bill on the lines indicated on the form. Then on the space provided next to these lines, enter the number(s) corresponding to the numbered paragraphs at the bottom of this form which describe the reason(s) for which the medical bill failed to qualify for application toward SOC. Some of these numbered paragraphs describe multiple, related items. The blank parenthetical enclosure "( )" after the applicable item should be checked.

E. "Hunt v Kizer Second Disapproval Letter" For Disapproved Old Medical Bills": The beneficiary has 10 days from the issuance date of the First Disapproval Letter (see above paragraph) to correct the problem which caused the medical bill(s) to be rejected. The county has discretion to increase this 10 day period by a reasonable amount. If the beneficiary fails to correct the problem by submitting replacement medical bill(s) or supporting documentation containing the missing verification information (see Section VI of this ACWDL, p. 19) where this is appropriate, or by otherwise providing sufficient additional, qualifying medical bills to meet the beneficiary's SOC where this is appropriate, by the end of the 10 day period, the county must complete and issue a "Hunt v. Kizer Second Disapproval Letter" (Second Disapproval Letter) (attached, see Exhibit A) to the beneficiary.

This Second Disapproval Letter, which will be a "Notice of Action" (NOA) advising the beneficiary of his/her rights to a fair hearing, must be issued within 30 days of the end of the above-mentioned 10 day period. The county must keep a copy of each Second Disapproval Letter which it issues.

The First and Second Disapproval Letters serve similar functions: informing the beneficiary that certain medical bills cannot be applied toward SOC until certain problems associated with those medical bills have been corrected. Neither form actually curtails a beneficiary's right to re-submit a medical bill once the problem with that bill has been corrected. Even the issuance of the Second Disapproval Letter does not bar the beneficiary from re-submitting a medical bill once the problem with that bill has been corrected.

When a beneficiary re-submits a medical bill for which the county has previously issued a First and Second Disapproval Letter, and the county rejects the bill for the reason(s) indicated on the previously issued disapproval letters, the county need not re-issue any additional disapproval letters for that bill unless the county discovers that it failed to list in the previously issued disapproval letters all of the reasons for which that medical bill should have been disapproved. If the bill is rejected for a reason not previously indicated, another Second Disapproval Letter must be issued.

IX. PROCEDURES FOR PROCESSING MEDICAL BILLS UNDER HUNT V KIZER

A. CURRENT Medical Bills MAY Be Brought To County: Beneficiaries may either have their provider complete the Share-of-Cost Form (MC 177) for medical services rendered in the current month, per traditional pre-Hunt procedure, or submit their current medical bills to their county welfare office per an option provided to them by the Hunt final settlement agreement. The county must then transcribe billing information from these bills onto the MC 177. Beneficiaries are encouraged to have their providers complete MC 177s for medical services provided in the current month and applied toward SOC in that month in order to ensure the accuracy of billing information and in order to avoid delays in processing current medical bills due to missing items of verification information; but beneficiaries cannot be required to have their provider complete the MC 177 for current medical bills.

B. Old Medical Bills MUST Be Brought To The County: Beneficiaries must submit to their county old medical bills which they wish to apply toward their SOC as old medical bills (for definition of current and old medical bills, see Section I of this document, p. 4.) Providers may not transcribe billing information from old medical bills onto the MC 177. Only the county shall transcribe billing information from an old medical bill onto the MC 177.

C. County Options For Processing Medical Bills Applied Toward SOC: "Adjusting SOC" On MEDS Or Completing The MC 177: The procedures in this

paragraph apply to current medical bills submitted to the county for application toward SOC, and to old medical bills submitted to the county for application toward SOC under the Standard, Paid Old Medical Bill and Alternative Remedy (procedures for processing old medical bills under the Retroactive Remedy are covered in Section II.C(i) of this document, p. 11.)

To meet his/her SOC, the beneficiary may submit to the county old medical bills, current medical bills, acceptable substitute bills, the MC 177 showing current medical expenses, or any combination of the above. The county must determine whether these submitted bills meet the beneficiary's SOC for the month. If they do, the county, at its option, may apply these bills toward the beneficiary's SOC through one, or a combination of both, of the two procedures described in the numbered paragraphs below. If the submitted medical bills fail to meet the beneficiary's SOC, the county should return the medical bills to the beneficiary. The county should maintain copies of these medical bills in its files.

The procedures for processing medical bills submitted by the beneficiary for application toward his/her SOC are as follows:

1-a. Completing the MC 177: The county may transcribe the necessary information from all medical bills brought to the county onto the beneficiary's "Record of Health Cost -- Share of Cost" form (MC 177). In such cases, the county will complete the blocks normally completed by the provider in addition to the other parts of the form normally completed by the county. These additional blocks include: the "Provider Medi-Cal Number," "14 Digit I.D. Number," "Service Dates," "Procedure/Drug Code," "Service Description," "Provider Name," the provider's signature block, "Amount Billed Patient," and "Unreimbursed Amount." In the provider's signature block, write "see attached," and attach a copy of all the transcribed medical bills, and supporting documentation, if any, to the MC 177. If the medical bill is missing information needed to fill out this part of the MC 177, see Section VIII of this ACWDL, p. 23. After the MC 177 is completed it is forwarded to the Department of Health Services.

1-b. Obtaining A Procedure Code For The MC 177: An old medical bill incurred by the beneficiary before January 1, 1992, need not contain a procedure code (all other bills must contain a procedure code --see Section III.B.4 of this ACWDL, p. 15. If the procedure code is missing from an old medical bill, the county should make a phone call to the provider and request the procedure code. If obtained, the procedure code must be entered onto the MC 177, and onto the county's copy of the old medical bill. Both entries should be initialed by the county worker making the entry. As an interim procedure, if the procedure code cannot be obtained, the county may leave the "Procedure Code" block on the MC 177 blank.

1-c. Obtaining The Unreimbursed Amount For the MC 177: When a beneficiary does not have other health care coverage, the amount which the provider has billed the beneficiary will be the provider's total bill for the service. In this case, the county must enter this billed amount in both the "Unreimbursed Amount"

block on the MC 177 (shown as "Total Bill" on old MC 177s) and the "Amount Billed Patient" block.

If the beneficiary submitting the bill has other health care coverage, the county must determine how much of the bill will be paid by the third party before accepting the bill for application toward the beneficiary's SOC. If the provider has entered on the bill both a total amount indicating what the total charge for the service is, and a separate, lesser figure as the amount owed by the beneficiary, the county may apply this lesser amount toward the beneficiary's SOC under the assumption that the provider is billing the beneficiary's insurer for the amount subject to third party payment. If the bill does not show a separate, lesser amount billed to the beneficiary, the beneficiary must demonstrate how much of the bill will be paid by the third party by submitting: 1) a statement from the provider indicating how much the provider believes will be paid by the insurer, 2) a statement from the insurer indicating how much of the bill will be paid by them, or 3) a check stub from the insurer which properly references the bill being paid and indicates how much was paid. These amounts must be subtracted from the total amount of the bill and the remainder applied toward SOC.

The amount entered by the county into the "Unreimbursed Amount" block and "Amount Billed Patient" block will be the same except when a bill, whether alone or totaled with the bills previously entered onto the MC 177, exceeds the beneficiary's SOC for the month. When a bill exceeds the SOC, the county should enter into the "Amount Billed Patient" block that portion of the bill necessary to meet the beneficiary's SOC for the month. The full amount billed to the beneficiary is entered in the "Unreimbursed Amount" block.

2. Processing Medical Bills On MEDS: To facilitate county processing of medical bills submitted by beneficiaries, for an interim period counties may, as an alternative to transcribing information from submitted medical bills onto the MC 177, "reduce" the beneficiary's SOC on the county's MEDS terminal by an amount corresponding to the amount of the medical expense billed to the beneficiary. The county may use the MEDS system alternative to the exclusion of the MC 177 when reducing the SOC for a Medi-Cal Family Budget Unit to zero, or the county may use the MEDS ~~system in conjunction~~ with the MC 177 by reducing SOC on MEDS to less-than-zero and then submitting a MC 177 to the Department for the remaining SOC. Do not lower SOC on MEDS to an amount which exceeds zero unless a MC 177 shall be submitted to meet the remaining balance of SOC. This will ensure that a beneficiary's medical bills are not applied toward SOC when in fact the beneficiary's SOC for the month was not met. This MEDS alternative should not be used for medical bills applied toward SOC under the Retroactive Medi-Cal Card Remedy.

When "adjusting" SOC on MEDS, counties must complete the relevant portions of the MC 176 M form. In the "Underpayment Adjustment

Box," column III, line 15, on this form, the county should enter the letters "OMB" for old medical bill, and record the beneficiaries SOC before and after adjustment. This record should be maintained in the case file.

When a county manipulates the MEDS SOC figure for a beneficiary, that case must be flagged manually or on MEDS (REDETERM-MONTH) so that the MEDS SOC figure can be reset to the beneficiary's actual SOC at the end of the submitted medical bill's effective period.

3. "Zeroing Out the SOC"--No SOC Aid Code: When a county reduces a beneficiary's SOC to zero on MEDS for a particular month, the county must change the beneficiary's aid code for that month to a no-SOC aid code. The certification date for the beneficiary having met his/her SOC should set at the first of the month to enable providers who rendered services to the beneficiary in that month to bill Medi-Cal regardless when in the month the services were rendered.

4. Combining Options: Counties may select between, or mix, options 1 and 2 as they see fit. (See above paragraph)

5. County Retention of Medical Bills: When a medical bill has been accepted by the county for application toward the beneficiary's SOC, the bill and any accompanying documentation must be retained by the county in the case file. Do not return the original bill or supporting documentation to the beneficiary. When a medical bill has been rejected, the county must return the original bill to the beneficiary. The county may photocopy the bill for its files.

Counties using MEDS to adjust SOC should devise tracking procedures to prevent beneficiaries' from re-submitting old medical bills already applied toward SOC. Copies of medical bills accepted toward SOC must be kept on record so that the Department of Health Services may review them.

X. INFORMING BENEFICIARIES OF THEIR RIGHTS UNDER THE HUNT LAWSUIT: DISTRIBUTING THE HUNT COMPREHENSIVE BENEFICIARY NOTICE AND THE MEDI-CAL PAMPHLET

A. Distributing The Hunt Comprehensive Beneficiary Notice: The Hunt comprehensive beneficiary notice (Exhibit B), distributed to beneficiaries by the Department of Health Services in a mailer on October 5, 1993, replaces the MC 177HK. Counties should discontinue distributing the MC 177HK on October 31, 1993. (Counties currently mail the MC 177HK with the MC 177.) The Hunt COMPREHENSIVE BENEFICIARY NOTICE (Exhibit B) MUST BE DISTRIBUTED BY COUNTIES to all Medi-Cal only applicants and to all transfers to Medi-Cal only from other welfare programs for a 6 month period COMMENCING OCTOBER 5, 1993 and ENDING APRIL 5, 1994. These beneficiary notices (see Exhibit B) will be available from the DHS warehouse around

mid-September, 1993. Distribute these Hunt comprehensive beneficiary notice as follows:

1. The comprehensive beneficiary notice must be provided to Medi-Cal applicants at the time they receive their Medi-Cal Statement of Facts form;

2. The comprehensive beneficiary notice must be provided to individuals whose eligibility is being redetermined as a result of their being discontinued from the Aid to Families with Dependent Children (AFDC) cash grant program, SSI cash grant program, or other cash grant program.

This procedure will ensure that individuals who become eligible for Medi-Cal during the first 6 months after the mailing of the comprehensive beneficiary notice, and who did not receive a notice through the initial mailing, will receive this notice. The county must distribute one notice to each beneficiary who becomes medically needy Medi-Cal eligible during this 6 month period. Counties are not required to distribute this comprehensive notice monthly with the SOC forms as they were required to do for the MC 177HK.

B. Distributing The Medi-Cal Pamphlet: Commencing April 6, 1994, (the date of expiration of the 6 month period specified in the paragraph above) the Medi-Cal Pamphlet will replace the comprehensive beneficiary notice. Discontinue distributing the comprehensive beneficiary notice. The Medi-Cal Pamphlet must be provided to individuals as enumerated below:

1. The Medi-Cal Pamphlet must be provided to Medi-Cal applicants at the time they receive their Medi-Cal Statement of Facts form;

2. The Medi-Cal Pamphlet must be provided to individuals whose Medi-Cal eligibility is being redetermined as a result of their being discontinued from the Aid Families with Dependent Children cash grant program, SSI cash grant program, or other cash grant program.

The Department encourages, but does not require, counties to also issue this Medi-Cal pamphlet to beneficiaries at their first face-to-face interview for annual redetermination after the Medi-Cal pamphlet is sent out.....This pamphlet need not be issued on a monthly or annual basis.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Exhibits

EXHIBITS TO ACWDL 93-63

EXHIBIT A

TRANSMITTAL MEMO: FORMS AND INFORMATIONAL LETTER REQUIRED BY THE HUNT V KIZER LAWSUIT

HUNT V KIZER MEDICAL BILLS APPROVED LETTER

HUNT V KIZER FIRST DISAPPROVAL LETTER

HUNT V KIZER SECOND DISAPPROVAL LETTER

MC 1054 HK

LETTER OF AUTHORIZATION

RECORD OF MEDICAL BILLS SUBMITTED AND ACCEPTED FOR APPLICATION TOWARD SHARE OF COST --HUNT V KIZER

To: Counties of the State of California

From: Department of Health Services

Re: FORMS AND INFORMATIONAL LETTERS REQUIRED BY THE HUNT V. KIZER LAWSUIT

The first three forms transmitted by this memo are utilized by counties when evaluating old medical bills submitted to them by beneficiaries. Counties must distribute these three forms, the Hunt approval letter, and two Hunt disapproval letters, to beneficiaries in order to advise them whether the medical bills they have submitted to the county have been disapproved or approved (see All County Welfare Directors Letter 93-63.) The county is not required to complete and distribute these forms when the medical expenses submitted by the beneficiary for application toward his/her SOC for the month have been recorded by the provider on the MC 177. The form titled "Hunt v Kizer Second Disapproval Letter" is a Notice of Action (NOA). For information regarding the purpose and utilization of these forms, consult Section VIII of this ACWDL 93-63.

English version and Spanish version camera-ready copies of these three forms are provided in Exhibit D, attached. Counties may reproduce these forms by computer-automation or by photocopy. Low levels of utilization by beneficiaries of Hunt benefits, as reported by counties, does not warrant the mass reproduction of these forms by the Department of Health Services at this time.

The MC 1054 HK in this Exhibit is a modified version of the MC 1054 and is utilized in the Hunt Retroactive Medi-Cal Card Remedy discussed in Section II.C of this ACWDL. It is still in draft form. This form will be finalized and a camera-ready copy distributed to counties shortly. Counties should also reproduce these forms by photocopying them or by generating them as computer printouts.

The Letter of Authorization in this Exhibit is a Medi-Cal form used in the Hunt Retroactive Medi-Card Remedy for which counties will be issuing retroactive Medi-Cal cards for months more than one year old. This form is not specific to Hunt. It is provided in this Exhibit so that counties may conveniently reference it.

This memo also transmits an additional form, titled "Record of Medical Bills Submitted and Accepted for Application Toward Share of Cost -- Hunt v. Kizer" which your county may wish to use for logging medical bills which have been submitted by the beneficiary, and accepted by the county for application toward the beneficiary's SOC (see Section VIII of the Hunt

Procedures ACWDL). This form may be modified to suit your county's needs. Your county may also wish to use this form as a template from which to design a log form for recording medical bills submitted by the beneficiary and rejected by the county, especially for recording medical bills which have been rejected only because insufficient medical bills which qualified under the Hunt requirements were submitted to meet SOC.

The Hunt final Settlement Agreement between the plaintiffs and the Department of Health Services will be distributed to counties after it received from the plaintiffs.

HUNT V KIZER MEDICAL BILLS APPROVED LETTER

Issuance Date: _____ (County Stamp)

For Medical Bills Submitted in the Month of: _____

Case Name: _____

Case Number: _____

District: _____

HUNT V. KIZER MEDICAL BILLS APPROVED LETTER

The medical bill(s) which you submitted were approved and applied toward your Share of Cost in the amount of:

$ _____
Total Share of Cost Credit

This amount will be applied toward your Share of Cost for the following months: _____

_____

_____

For medical bills which are disapproved, if any, you will receive separate notification which will identify which old medical bills were disapproved and the reasons for the disapproval.

Please call your Eligibility Worker (EW), below, if you have questions.

_____ _____ _____
(Eligibility worker) (Phone number) (Date)

This action is authorized under the Hunt v. Kizer lawsuit.

Fecha de Emisión: _____

Para Gastos Médicos Presentados Durante el Mes de: _____

(Sello del Condado)

Nombre del Caso: _____

Número del Caso: _____

Distrito: _____

CARTA DE APROBACION DE LOS GASTOS MEDICOS EN CONFORMIDAD CON LA DEMANDA HUNT vs. KIZER

El cobro(s) médico que se presentó se aprobó y se aplicó para cumplir con su Parte del Costo por la cantidad de:

$ _____
Crédito Total de la Parte del Costo

Esta cantidad se aplicará para cumplir con su Parte del Costo para los siguientes meses: _____

_____

_____

En cuanto a los cobros médicos que se desaprobaron, si hay alguno, usted recibirá una notificación por separado, que le indicará qué cobros médicos pasados se desaprobaron y las razones para tal desaprobación.

Si tiene alguna pregunta, por favor llame a su Trabajador(a) de Elegibilidad, que se nombra en seguida.

_____ _____ _____
(Trabajador(a) de Elegibilidad) (Número de Teléfono) (Fecha)

La demanda Hunt vs. Kizer autoriza esta acción.

HUNT V KIZER FIRST DISAPPROVAL LETTER

Fecha de Emisión: _____

Para Gastos Médicos Presentados Durante el Mes de: _____

(Sello del Condado)

Nombre del Caso: _____

Número del Caso: _____

Distrito: _____

PRIMERA CARTA DE DESAPROBACION EN CONFORMIDAD CON LA DEMANDA HUNT vs. KIZER

(Se necesita más información sobre sus cobros médicos)

Usted trajo al condado algunos cobros médicos para que se aplicaran a su Parte del Costo (SOC). Actualmente, el condado no puede aceptar algunos de estos cobros médicos. Para determinar la razón por la cual los cobros médicos, enumerados a continuación, no se pueden utilizar, encuentre el número que aparece en la línea identificada como "Razones para la desaprobación", que aparece a continuación, en seguida del cobro enumerado, y entonces lea el párrafo que sigue identificado con el mismo número. Estos párrafos numerados son las razones para la desaprobación, las cuales le indican la razón por la cual los cobros médicos que usted presentó no se pueden utilizar y lo que usted puede hacer para corregir el problema.

Para las razones de desaprobación (párrafos numerados) del 1 al 10 a continuación, usted puede corregir el problema obteniendo otro cobro de su proveedor, o bien una copia del cobro que contenga las iniciales, o la firma, o el sello del proveedor, u obteniendo una declaración aceptable de un representante autorizado de su proveedor, que muestre la información que faltaba. Entregue este cobro revisado a su trabajador(a) de elegibilidad.

Si cualesquiera de sus cobros médicos han sido desaprobados debido a las razones para negación del 1 al 6, a continuación, y si usted no puede obtener información por escrito de su proveedor, después de esforzarse por hacerlo, pero usted sabe la información que falta, es posible que se le permita presentar una declaración jurada en la que proporcione la información que falte.

Usted tiene que proporcionar la información que falta a su trabajador(a) de elegibilidad, a más tardar el (fecha)_____o los cobros médicos se desaprobarán de nuevo. A continuación se indica la información que se necesita y los cobros médicos para los cuales se requiere.

LISTA DE COBROS MEDICOS DESAPROBADOS
(De acuerdo al nombre del proveedor, fecha y cantidad del cobro)

(Nombre del proveedor)	(Fecha del cobro)	(Cantidad del cobro)	(Razones para la desaprobación)

RAZONES PARA LA DESAPROBACION

1. El nombre ( ), y/o la dirección ( ) del proveedor que proveyó el servicio médico no aparecía en el cobro médico. Obtenga esta información, por favor.

2. El nombre de la persona que recibió el servicio médico no aparecía en el cobro médico. Obtenga esta información, por favor.

3. No aparecía en el cobro médico, una descripción breve de la clase de servicio médico que se recibió. Obtenga esta información, por favor.

4. La clave de procedimiento (un número de referencia médica utilizado para identificar la clase de servicio recibido) no aparece en el cobro médico. Obtenga esta información, por favor.

5. El cobro médico no muestra el número de identificación del proveedor. Para los proveedores de Medi-Cal, por favor obtenga el número de identificación del proveedor de Medi-Cal. Para los proveedores que no son proveedores de Medi-Cal, por favor obtenga el número de licencia o el número de identificación para impuestos federales del proveedor.

6. La(s) fecha(s) en que el servicio se proporcionó no aparecía en el cobro médico. Obtenga esta información por favor.

Para la información solicitada en los números del 7 al 11, en seguida, no será suficiente su declaración jurada. Usted tiene que obtener un cobro nuevo que contenga la información según se explica anteriormente.

7. Falta la fecha en que se emitió el cobro ( ) o el cobro médico no se emitió en un plazo de 90 días contados a partir de la fecha en que el condado lo recibió ( ). Por favor obtenga un reemplazo fechado en un plazo de 90 días contados a partir de la fecha en que el condado lo recibió.

8. El cobro médico no muestra el saldo actual que aún no se ha pagado, y del cual usted es el único responsable ante su proveedor o usted ya no es responsable de tal cobro. Por favor obtenga un reemplazo que muestre esta información, a menos que usted ya no sea responsable del cobro. Si usted ya no es responsable del cobro, éste no se puede aplicar para cumplir con su Parte del Costo.

9. El cobro médico presentado no era una copia auténtica o fue modificado. Por favor obtenga un reemplazo auténtico, sin modificaciones.

10. Usted no presentó suficientes cobros médicos que reunieran los requisitos para cumplir con su Parte del Costo. Por favor presente cobros médicos adicionales o corrija los problemas con los cobros médicos que presentó anteriormente y vuélvalos a presentar.

11. Otra: _____

_____

_____

_____

_____

_____

12. Este cobro médico ya se ha aplicado para cumplir con su Parte del Costo.

13. Este cobro no reúne los requisitos para que se le considere un gasto médico.

14. Este cobro no era un cobro que no se ha pagado.

Si necesita ayuda, por favor llame a su Trabajador(a) de Elegibilidad, que se nombra a continuación.

_____ _____ _____

(Trabajador(a) de elegibilidad) (Número de teléfono) (Fecha)

La demanda Hunt vs. Kizer autoriza esta acción.

HUNT V KIZER SECOND DISAPPROVAL LETTER

Issuance Date: _____ (County Stamp)

MEDI-CAL
NOTICE OF ACTION

Case Name: _____

Case Number: _____

District: _____

HUNT V. KIZER SECOND DISAPPROVAL LETTER

For Medical Expenses Submitted in the Month of: _____

You previously submitted medical bills to your county for application toward your SOC which were rejected. This will inform you which of these medical bill(s) continue to be disapproved. These disapproved medical bills are listed below. They cannot be used to meet your SOC until you correct the problems with these bills. The reason(s) for the disapproval is/are listed below.

(Provider name)	(Date of bill)	(Amount of bill)	(Disapproval reason(s))

DISAPPROVAL REASONS

1. Provider's name and/or address missing.
2. Name of person who received the medical services missing.
3. Description of service missing.
4. Procedure Code missing. (The procedure code is a medical reference number identifying the kind of medical service received.)
5. Provider's Medi-Cal provider number, license number, or federal tax identification number missing.
6. Date(s) medical service was provided missing.
7. Bill does not show a billing date; or bill was received by county over 90 days from date of bill.
8. Bill does not show amount currently owed solely by the beneficiary; or beneficiary is not liable for part, or all, of bill.
9. Original billing statement —or acceptable substitute— not provided; (bill was altered or unauthenticated copy.)
10. You did not submit enough qualifying old medical bills to meet your Share of Cost.
11. Other: _____
12. Bill previously used to meet Share of Cost.
13. Bill does not qualify as a medical expense.
14. Bill was not an unpaid bill.

A medical bill which has been disapproved may be re-submitted if the missing information is obtained. See the First Disapproval Letter for more information.

Please call your Eligibility Worker, below, if you have questions.

(Eligibility worker) (Phone number) (Date)

This action is authorized under the Hunt v. Kizer lawsuit.

YOUR HEARING RIGHTS

To 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.

To 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.

To 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

To 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:

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

HEARING REQUEST

I want a hearing because of an action by the Welfare Department of _____ County about my

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) _____

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: _____

Fecha de Emisión_____

(Sello del Condado)

NOTIFICACION DE ACCION MEDI-CAL

Nombre del Caso: _____

Número del Caso: _____

Distrito: _____

SEGUNDA CARTA DE DESAPROBACION HUNT vs. KIZER

Para los Gastos Médicos Presentados Durante el Mes de: _____

Anteriormente, usted presentó cobros médicos a su condado para que éstos se aplicaran a su Parte del Costo (SOC), y éstos fueron rechazados. Esta notificación le informa cuáles de estos cobros médicos continuarán siendo desaprobados. Estos cobros médicos desaprobados se enumeran a continuación. Estos no se pueden utilizar para cumplir con su Parte del Costo (SOC), hasta que usted corrija los problemas con estos cobros. La(s) razón(es) para la desaprobación se enumera(n) en seguida.

(Nombre del proveedor)	(Fecha del cobro)	(Cantidad del cobro)	(Razón(es) para la desaprobación)

RAZONES PARA LA DESAPROBACION

1. No aparece el nombre y/o la dirección del proveedor.
2. No aparece el nombre de la persona que recibió los servicios médicos.
3. No aparece la descripción del servicio.
4. No aparece la clave de procedimiento. (La clave de procedimiento es un número de referencia médica que identifica la clase de servicio médico recibido.
5. No aparece el nombre del Proveedor de Medi-Cal, el número de licencia, o el número de identificación para impuestos federales.
6. No aparece(n) la(s) fecha(s) en que se proporcionó el servicio médico.
7. El cobro no muestra la fecha de cobro; o el condado recibió el cobro más de 90 días después de la fecha del cobro.
8. El cobro no muestra la cantidad que sólo el beneficiario debe actualmente; o el beneficiario no es responsable de parte del cobro, o de todo el cobro.
9. No se proporcionó la factura original de cobro — o un substituto aceptable. (El cobro se modificó o se hizo una copia que no es auténtica.)
10. Usted no presentó los suficientes cobros médicos que reunieran los requisitos para cumplir con su Parte del Costo.
11. Otro: _____
12. El cobro se utilizó anteriormente para cumplir con su Parte del Costo.
13. El cobro no reúne los requisitos para considerarse como un gasto médico.
14. El cobro no era un cobro que no se había pagado.

Es posible que un cobro médico que ha sido desaprobado, se pueda volver a presentar si se obtiene la información que faltaba. Para mayores informes, vea la Primera Carta de Desaprobación.

Si usted tiene alguna pregunta, por favor llame a su Trabajador(a) de Elegibilidad, que se nombra en seguida.

(Trabajador(a) de elegibilidad)	(Número de teléfono)	(Fecha)

Esta acción se autorizó en conformidad con la demanda Hunt vs. Kizer.

SUS DERECHOS A UNA AUDIENCIA

Para 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.

Para conservar sus mismos beneficios mientras espera una audiencia

Debe 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 cualesquier dinero o estampillas para comida que haya recibido.

Para 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

Para 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:

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 Bienestar del Condado de _____ acerca de mi:

☐ Asistencia monetaria ☐ Estampillas para Comida

☐ Medi-Cal

☐ Otro (anote)_____

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: _____

MC 1054 HK

(MC1054HK.692)

DRAFT DRAFT DRAFT DRAFT

STATE OF CALIFORNIA-
HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

MEDI-CAL HUNT V KIZER
PROVIDER LETTER

(County Address)

(Provider Address)

Medi-Cal Beneficiary Name _____ I.D. No. _____

The individuals(s) shown above was determined eligible for the Hunt v Kizer Retroactive Medi-Cal Card Remedy. In addition to this form, he/she must present to you a "Letter of Authorization" completed and signed by the county welfare department, a Retroactive Medi-Cal Card(s) showing the months for which the individual is eligible to participate in this remedy, and a Share of Cost form (MC 177) completed and signed by the County Welfare Department for each of the months for which the beneficiary is eligible, and which shows the medical expenses which were used to meet the beneficiary's SOC for that month.

Under this remedy, Medi-Cal beneficiaries will receive reimbursement or cancellation of indebtedness from health care providers (who were enrolled Medi-Cal providers at the time the service was provided), as provided below.

Instructions For Provider Participation

1. Please bill Medi-Cal for service(s) you provided the beneficiary for any month(s) from July, 1988 through May, 1990 covered by the beneficiary's accompanying retroactive Medi-Cal card(s) WHICH DO NOT APPEAR ON THE accompanying MC 177, except that the provider may bill Medi-Cal for that portion, if any, of the last service entered on the MC 177 which was not needed to meet the beneficiary's share of cost (SOC). Upon receiving payment from Medi-Cal for the service(s), reimburse the beneficiary for the amount he/she paid you for that service(s), and cancel any of the beneficiary's remaining indebtedness to you for that service(s).

2. If the service(s) for which you will be billing Medi-Cal under this Hunt v Kizer remedy HAVE NOT been previously billed to Medi-Cal, submit a billing claim to Medi-Cal, attaching to the claim the "Letter of

Authorization," this MC 1054 HK, and a "Proof of Authorization (POE)" label from the retroactive Medi-Cal card for the retroactive month(s). You do not need to make an entry in the "Patient's Share of Cost" block on your claim form.

3. If some portion of the services(s) for which you will be billing Medi Cal under this remedy has been previously billed to and paid by Medi-Cal (the beneficiary paid or obligated to pay for the other part of the service to meet his/her SOC), complete and submit a Claims Inquiry Form (CIF) to Medi-Cal, attaching the "Letter of Authorization" and this MC 1054 HK. DO NOT submit a new claim, as it will be considered a duplicate claim and payment will be denied.

4. Both billing claims and CIFs submitted to Medi-Cal under this remedy should be sent to:

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

5. For medical services which you are now billing to Medi-Cal under this remedy, it is not necessary, before submitting a claim to Medi-Cal, to obtain a "Medi" label, or to obtain approval of a Treatment Authorization Request for services normally requiring such approval. Medi-Cal waives these requirements for bills submitted under this remedy.

6. You cannot participate in this remedy nor bill Medi-Cal if you were not enrolled as a Medi-Cal provider in the month(s) in which the services you are billing to Medi-Cal were provided. If you were enrolled as a Medi-Cal provider in the month in which provided the service, it is not necessary for you to be currently enrolled as a Medi-Cal provider before billing Medi-Cal for that service.

The Welfare and Institutions Code, Section 14019.3 requires providers to cooperate with the Department of Health Services in making reimbursements to beneficiaries for Medi-Cal program underpayments to these beneficiaries. The Welfare and Institutions Code, Section 14019.3, further requires that the provider accept payments from the Medi-Cal program for services rendered to the beneficiary as payment in full for those services.

Eligibility Worker's Signature _____ Phone No. _____ Date _____

MC 1054 HK (date)

LETTER OF AUTHORIZATION

Letter of Authorization
(must be on county letterhead

Date: _____

(Applicant's Name)
(Address)
(Medi-Cal ID #)
Date of Application: Date Case Approved:

Dear _____:

Regarding Medi-Cal Cards for _____
Month(s)

Worker: Phone Number:

Attached are your replacement Medi-Cal labels for the above month(s) 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 to beneficiaries more than one year after the month of service for limited reasons.

Your card is being issued for the reason checked below:

_____ A court order requires that a card be issued.
_____ A State Hearing or other administrative hearing decision requires that a card be issued.
_____ The Department of Health Services requests that a card be issued.
[Signature or authorized DHS staff person
_____]
_____ An Administrative Error has occurred.
(Description)_____

Please give your doctor or other medical provider this letter, along with your Medi-Cal label(s) for the month(s) of service. The Medi-Cal program cannot pay your provider's bill unless the original of this letter is submitted with the bill and your Medi-Cal label(s) for the month(s) of service.

If you are going to give a Medi-Cal label to more than one doctor or other provider, please contact us at _____ We will send you more of these letters for each doctor or other provider you give a label to.

If you have any questions, please call your worker.

Sincerely,

(Original Signature of Authorized County Administrative Staff)

Instruction to Provider

Submit this letter, along with the claim, to:

EDS Federal Corporation
P.O. Box 13029
Sacramento, CA 95813-4029

Regulation #: 50746

Example Form

Example Form

Letter of Authorization
(must be on county letterhead

Date: 9/2/92

(Applicant's Name)
(Address)
(Medi-Cal ID #)
Date of Application: Date Case Approved:

Dear Medi-Cal Beneficiary:

Regarding Medi-Cal Cards for July, 1988
Month(s)

Worker: Phone Number:

Attached are your replacement Medi-Cal labels for the above month(s) 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 to beneficiaries more than one year after the month of service for limited reasons.

Your card is being issued for the reason checked below:

✓ A court order requires that a card be issued. (Hunt v. Kizer lawsuit

___ A State Hearing or other administrative hearing decision requires that a card be issued.

___ The Department of Health Services requests that a card be issued. [Signature or authorized DHS staff person _____]

___ An Administrative Error has occurred. (Description) _____

Please give your doctor or other medical provider this letter, along with your Medi-Cal label(s) for the month(s) of service. The Medi-Cal program cannot pay your provider's bill unless the original of this letter is submitted with the bill and your Medi-Cal label(s) for the month(s) of service.

If you are going to give a Medi-Cal label to more than one doctor or other provider, please contact us at 747-1234. We will send you more of these letters for each doctor or other provider you give a label to.

If you have any questions, please call your worker.

Sincerely, Ms. Reese

(Original Signature of Authorized County Administrative Staff)

Instruction to Provider

Submit this letter, along with the claim, to:

EDS Federal Corporation
[illegible]
Sacramento, CA 95813-4029

Regulation # 50746

RECORD OF MEDICAL BILLS SUBMITTED AND ACCEPTED FOR APPLICATION TOWARD SHARE OF COST --HUNT V KIZER

Date _____

Medical bills submitted for month of: _____.

Case Identification: _____.

(Purpose of form: Counties may want to fill out this form and attach a copy of this form to the copy of the Hunt Approval Notice which the county keeps for its files so that the county knows which medical bills were approved.)

RECORD OF MEDICAL BILLS SUBMITTED AND ACCEPTED FOR APPLICATION TOWARD SHARE OF COST -- HUNT V. KIZER

Medical Bills Submitted:

(Provider name)	(Date of bill)	(Date of Service)	(Amount of Bill)

EXHIBIT B

HUNT V KIZER BENEFICIARY NOTICE, "YOUR RIGHTS TO USE OLD MEDICAL BILLS TO MEET YOUR SHARE OF COST"

Date of Notice: October 5, 1993

YOUR RIGHTS TO USE OLD MEDICAL BILLS TO MEET YOUR SHARE OF COST

1. If you have a Share of Cost now, this notice gives you important information about how to get a Medi-Cal card from now on.
2. If you had a Share of Cost for any month from July 1988 through May 1990, this notice gives you important information about how to claim a back or a future Medi-Cal card. You only have until six months from the date of this notice to make this kind of claim. **Every time this notice says you must do something within six months of the date of this notice we mean you must do it by April 5, 1994.**

INTRODUCTION

This notice explains about different ways people who are on Medi-Cal or who used to be on Medi-Cal may use medical bills from prior months to meet their Share of Cost. Medical bills from prior months are called old medical bills.

What is Share of Cost? It is the monthly amount you pay or owe for medical services before you receive a Medi-Cal card. When we say "you," we mean you and your family.

Until recently, you could use toward your Share of Cost only medical bills from the same month in which you wanted to get a Medi-Cal card. The rule was changed by the Hunt v. Kizer lawsuit (US Dist Ct, Est Dist CA # CIVS-89-0836 EJG JFM). Now you may also use old medical bills toward your Share of Cost.

The ways in which you may use your old medical bills toward your Share of Cost are explained below. The ways described below will not affect the way you use "current" medical bills. Current medical bills are bills which arose in the same month in which you want to use them toward your Share of Cost. As you have in the past, you may continue to use these current medical bills toward your Share of Cost whether they are PAID or UNPAID.

Section A. TO CLAIM BACK-BENEFITS:

This section tells you about two ways you may get back-benefits. Part 1 of this section may apply to you if you have a Share of Cost as of the date of this notice. Part 2 of this section may apply to you if you had a Share of Cost for any month from July 1988 through May 1990.

1. USING PAID OLD MEDICAL BILLS TOWARD YOUR SHARE OF COST TO GET A CURRENT OR FUTURE MEDI-CAL CARD

You may use old medical bills toward your Share of Cost even though these medical bills are PAID if you were:

- On Medi-Cal with a Share of Cost as of the date of this Notice.

To use PAID medical bills toward your Share of Cost:

- The medical bills must have been unpaid at any time from July 1988 through May 1990 and
- You must give the medical bills to your county welfare department within six months of the date of this notice. (After six months from the date of this notice, only UNPAID medical bills may be used toward your Share of Cost.)

You must give these paid old medical bills to your county welfare department in the month for which you want your Medi-Cal card. If you give the county welfare department a bill(s) which is larger than your Share of Cost for the current month, the bill(s) shall be used toward your Share of Cost for future consecutive months until used up.

You can not use paid old medical bills toward your Share of Cost if you were a Medi-Cal beneficiary who never had a Share of Cost during July 1988 through May 1990.

This will NOT provide you with a cash payment. You will receive an adjustment in your Share of Cost for current and/or future month(s).

– Versión en español en el dorso –

2. USING PAID OR UNPAID OLD MEDICAL BILLS TOWARD YOUR SHARE OF COST TO GET A MEDI-CAL CARD FOR A PAST MONTH.

You may be able to get a Medi-Cal card for one or more months from July 1988 through May 1990 if:

- You are not on Medi-Cal now or you get Medi-Cal now with no Share of Cost, and
- You were on Medi-Cal with a Share of Cost in one or more months from July 1988 through May 1990.

To get a Medi-Cal card for a past month, you must:

- Have old paid or unpaid medical bills which were unpaid at any time in the month in which you wish to use your bills to get a Medi-Cal card for a past month (it does not matter if you paid these bills at a later time), and
- Give these old medical bills to your county welfare department within six months of the date of this notice.

This past month Medi-Cal card will allow providers to bill Medi-Cal for other medical services you received in the past month. If you have already paid for these other medical services, the providers must then reimburse you in full after they have been paid by Medi-Cal. You will NOT be reimbursed for the old bills used to meet your Share of Cost.

If you do not want a Medi-Cal card for a past month, you may be able to use these paid or unpaid old medical bills toward your Share of Cost to get current and future Medi-Cal cards. To do this, you must first become a Medi-Cal beneficiary with a Share of Cost at some time before six months from the date of this notice.

Section B. TO GET CURRENT AND FUTURE MEDI-CAL CARDS:

If you have a Share of Cost now, this section applies to you.

USING UNPAID OLD MEDICAL BILLS TOWARD YOUR SHARE OF COST TO GET A CURRENT OR FUTURE MEDI-CAL CARD.

You may use old medical bills toward your Share of Cost in the current month or in a future month if:

- The bills are **UNPAID** and
- You are **STILL LIABLE** for the medical bills.

You must give these unpaid old medical bills to your county welfare department in the month for which you want your Medi-Cal card. If you give the county welfare department a bill(s) which is larger than your Share of Cost for the current month, the bill(s) shall be used toward your Share of Cost for future consecutive months until used up.

This will NOT provide you with a cash payment. You will receive an adjustment in your current or future month's Share of Cost.

Section C. PROCEDURES FOR USING OLD MEDICAL BILLS:

PROCEDURE FOR PROCESSING AND RECORDING YOUR OLD MEDICAL BILLS

If you are a Medi-Cal beneficiary with a Share of Cost, you receive a "Record of Health Care Costs" form (called MC 177) each month. Take the form and any old medical bills you wish to use toward your Share of Cost to your eligibility worker. Only your eligibility worker or county representative can fill out the form for old medical bills.

For current bills you wish to use in the current month, you may still get your provider's signature on the Share of Cost form just as you have always done.

YOUR MEDICAL BILL(S) MUST QUALIFY

To use a medical bill toward your Share of Cost, the medical bill must show:

1. Name and address of the provider who provided the service.

2. Either the provider's Medi-Cal identification number, taxpayer identification number, or provider license number. (Most medical bills show this number; if yours does not, ask your provider to write it on the bill.)
3. The date(s) the service was provided.
4. The type of service provided, including a procedure code if the bill is incurred after January 1, 1992.
5. Name of the person receiving the service.
6. The amount that you currently owe the provider.
7. The date of the bill. (For old unpaid medical bills you wish to use toward your Share of Cost, the billing date must be within 90 days of the date you give the bill to your county welfare department; this requirement does not apply to old paid medical bills which qualify to be used toward your Share of Cost.)

If an old medical bill does not contain this information, you must try to get an additional statement from your provider which shows this information. If you are unable to get this information, your eligibility worker must help you get the missing information from your provider. If your eligibility worker cannot get this information, you may be able to supply the missing information by making a sworn statement.

Please note that in order to use an old medical bill toward your Share of Cost, the old medical bill must not have been used toward your Share of Cost in a prior month.

HOW OLD CAN A BILL BE?

After a medical bill is four years old, generally it may not be used toward your Share of Cost because under the law, you are no longer liable for a debt this old. However, there are exceptions to this rule, and, if you are still liable for the old medical bill under one of these exceptions, your old medical bill may still be used toward your Share of Cost. To the extent that it is consistent with California laws and Code of Civil Procedure Section 337, Medi-Cal considers that you are still liable to pay a medical bill more than four years old if you show that:

- The medical expense is actually less than four years old; or
- The medical expense has been reduced to a court judgment; or
- There is a contract extending the statute of limitations for the expense; or
- Any payment has been made on the expense within the last four years; or
- There is an agreement to pay on the expense; or
- There is other reasonable verification showing that you are still responsible for the expense.

COLLECTIONS AND CREDIT CARD STATEMENTS

Billing statements from collection agencies and, under certain conditions, credit card statements may be used as evidence of medical expenses. Such statements, either alone or with a medical bill from your provider, must satisfy items 1 - 7 in the section above, titled "Your Medi-Cal Bills Must Qualify," before they can be used toward your Share of Cost. These statements may also be taken in to your eligibility worker along with a medical bill from your provider to update a provider bill or to show the amount owing on the bill.

YOU WILL BE INFORMED HOW TO CORRECT OLD MEDICAL BILLS NOT ACCEPTED BY YOUR COUNTY

If your county welfare department decides that you cannot use an old medical bill toward your Share of Cost, you will receive a notice stating the reason for the denial. You will have 10 days to correct the problem and return the bill to the county. If you do not do this, you will receive a denial notice within the next 30 days. It will state the reason for the denial and it will advise you of what you must correct before you may return your medical bill to the county.

For medical bills which have been accepted and used toward your Share of Cost, you will receive an approval notice.

QUESTIONS?

If you have any questions about how the Medi-Cal Share of Cost program works, you may ask your eligibility worker for assistance or call your local legal aid or legal services office.

The Hunt v. Kizer settlement did not decide whether some things may be used to meet a Share of Cost, such as finance charges, loans, some credit card charges and some expenses when you have insurance. The case did not decide whether long term care patients can use all the procedures in this notice to meet their Shares of Cost.

KEEP THIS NOTICE. Referring to it will help you meet your Share of Cost and get Medi-Cal cards from now on.

NOTICE OF HEARING

- If you are a person who is, was, or could have been eligible for medically needy Medi-Cal with a Share of Cost assessed in any month, or
- If you will be eligible for medically needy Medi-Cal and you will have a Share of Cost assessed in the future,

Your rights will be affected by the settlement of a lawsuit named George Hunt, et al., v. Kenneth Kizer, et al. The lawsuit alleges in part that California Department of Health Services has violated federal laws and regulations in its operation of California's medically needy Medicaid program, also known as the medically needy Medi-Cal or Medi-Cal Share of Cost Program. A description of the settlement reached in this lawsuit is contained in this notice.

The full terms of the settlement are on file with the Clerk of the Court, United States Courthouse, 650 Capitol Mall, Sacramento, California 95814.

A hearing will be held on November 19, 1993 at 9:00 A.M. in Courtroom 1 of the United States District Court, United States Courthouse, 650 Capitol Mall, Sacramento, California, at which time the Court will decide whether to approve this final settlement agreement.

If you agree with this settlement, you do not have to do anything. If you do not agree with the settlement, you must write a letter to one of the attorneys for the class members stating your reasons for objecting to the proposed settlement. The attorney's name and address are:

Eugenie Denise Mitchell
Legal Services of Northern California
515 - 12th Street
Sacramento, CA 95814

Your letter must be postmarked no later than November 5, 1993.

If you send such a letter, you or your attorney acting on your behalf may appear at the hearing and present any evidence or argument relevant to the fairness of the settlement.

Any member of the class who does not make and serve his or her written objections in the manner provided above shall be deemed to have waived such objections and shall forever be foreclosed from making any objections (by appeal or otherwise) to the proposed settlement.

For more information about the settlement, you can contact any of the following attorneys for the plaintiffs: Legal Services of Northern California, Sacramento Office (916) 444-6760 (Sacramento) or tollfree (800) 468-8890 ext. 146 (Northern California), or Mother Lode Regional office (916) 823-7560 (Auburn) or tollfree (800) 660-6107 (Northern California); Western Center on Law and Poverty, Los Angeles Office, (213) 487-7211; National Health Law Program, Los Angeles Office (310) 204-6010.

Fecha de la Notificación: 5 de octubre de 1993

SU DERECHO A UTILIZAR COBROS MEDICOS PASADOS PARA CUMPLIR CON SU PARTE DEL COSTO

1. Si usted paga ahora una Parte del Costo, esta notificación contiene información importante sobre cómo obtener una tarjeta de Medi-Cal de ahora en adelante.
2. Si usted tuvo que pagar una Parte del Costo para cualquier mes de julio de 1988 a mayo de 1990, esta notificación le proporciona información importante sobre cómo reclamar una tarjeta de Medi-Cal pasada o futura. Usted sólo tiene un plazo de seis meses, contados a partir de la fecha de esta notificación para hacer esta clase de reclamo. **Cada vez que esta notificación le indique que tiene que hacer algo en un plazo de seis meses, contados a partir de la fecha de la misma, queremos decir que tiene que hacerlo a más tardar el 5 de abril de 1994.**

INTRODUCCION

Esta notificación explica las diferentes maneras en que las personas que reciben o recibían Medi-Cal pueden utilizar los cobros médicos de meses anteriores para cumplir con su Parte del Costo. A los cobros médicos de los meses anteriores se les llama cobros médicos pasados.

¿Qué es Parte del Costo? Es la cantidad mensual que usted paga o debe por concepto de servicios médicos antes de recibir una tarjeta de Medi-Cal. Al decir "usted", nos referimos a usted y su familia.

Hasta hace poco tiempo, usted sólo podía utilizar cobros médicos del mismo mes en que usted quería obtener una tarjeta de Medi-Cal para cumplir con su Parte del Costo. La regla ha cambiado debido a la demanda Hunt vs. Kizer (US Dist Ct, Est Dist CA #CIVS-89-0836 EJG JFM). Ahora usted también puede utilizar cobros médicos pasados para cumplir con su Parte del Costo.

Las maneras en que usted puede utilizar sus cobros médicos pasados para cumplir con su Parte del Costo se explican a continuación. Las maneras que se describen abajo no afectarán la manera en que usted utiliza sus cobros médicos "actuales". Los cobros médicos actuales son cobros que se originaron durante el mismo mes en que usted quiere utilizarlos para cumplir con su Parte del Costo. Usted puede continuar utilizando estos cobros médicos actuales para cumplir con su Parte del Costo, HAYAN o NO sido pagados, como lo ha hecho en el pasado.

Sección A. EL RECLAMO DE BENEFICIOS PASADOS:

Esta sección le indica dos maneras en que usted puede obtener beneficios pasados. La Parte 1 de esta sección puede ser pertinente para usted si tiene una Parte del Costo hasta la fecha de esta notificación. La Parte 2 de esta sección puede ser pertinente para usted si tuvo una Parte del Costo correspondiente a cualquier mes de julio de 1988 a mayo de 1990.

1. EL USO DE COBROS MEDICOS PASADOS YA PAGADOS PARA CUMPLIR CON SU PARTE DEL COSTO PARA OBTENER UNA TARJETA DE MEDI-CAL ACTUAL O FUTURA.

Usted puede utilizar los cobros médicos pasados para cumplir con su Parte del Costo, aunque éstos YA HAYAN SIDO PAGADOS, si usted:

- recibía Medi-Cal pagando una Parte del Costo, hasta la fecha de esta Notificación.

Para utilizar cobros médicos YA PAGADOS para cumplir con su Parte del Costo:

- Los cobros médicos no tenían que haber sido pagados en cualquier momento de julio de 1988 a mayo de 1990, y
- Usted tiene que dar los cobros médicos a su departamento de bienestar del condado, en un plazo de seis meses, contados a partir de la fecha de esta notificación. (Después de seis meses, contados a partir de la fecha de esta notificación, sólo los cobros médicos que NO HAN SIDO PAGADOS pueden ser utilizados para cumplir con su Parte del Costo).

Usted tiene que dar estos cobros médicos pasados, ya pagados, a su departamento de bienestar del condado durante el mes para el cual usted quiere su tarjeta de Medi-Cal. Si usted le da al departamento de bienestar del condado cobros más grandes que su Parte del Costo para el mes actual, se usarán los cobros para cumplir con su Parte del Costo para meses consecutivos futuros, hasta que se agote.

Usted no puede utilizar cobros médicos pasados, ya pagados, para cumplir con su Parte del Costo, si usted era un beneficiario de Medi-Cal que nunca tuvo una Parte del Costo de julio de 1988 a mayo de 1990.

Esto NO le proporcionará un pago en efectivo. Usted recibirá un ajuste en su Parte del Costo para el(los) mes(es) actual(es) y/o futuro(s).

— English version on the other side —

2. EL USO DE COBROS MEDICOS PASADOS, YA PAGADOS O SIN PAGAR, PARA CUMPLIR CON SU PARTE DEL COSTO PARA OBTENER UNA TARJETA DE MEDI-CAL PARA UN MES PASADO.

Es posible que usted pueda obtener una tarjeta de Medi-Cal para uno o más meses de julio de 1988 a mayo de 1990 si:

- usted no recibe Medi-Cal ahora o usted recibe Medi-Cal ahora sin una Parte del Costo, y
- usted recibía Medi-Cal con una Parte del Costo durante uno o más meses de julio de 1988 a mayo de 1990.

A fin de obtener una tarjeta de Medi-Cal para un mes pasado, usted tiene que:

- tener cobros médicos pasados ya pagados o sin pagar, que no habían sido pagados en cualquier momento durante el mes en el cual usted desea utilizar sus cobros para obtener una tarjeta de Medi-Cal para un mes pasado (no importa si usted pagó estos cobros tiempo después), y
- dar estos cobros médicos pasados a su departamento de bienestar del condado, en un plazo de seis meses, contados a partir de la fecha de esta notificación.

Esta tarjeta de Medi-Cal para el mes pasado permitirá a los proveedores cobrar a Medi-Cal otros servicios médicos que usted recibió en el mes pasado. Si usted ya ha pagado esos otros servicios médicos, los proveedores entonces tienen que reembolsarle a usted por completo, una vez que Medi-Cal les haya pagado a ellos. A usted NO se le reembolsarán los cobros pasados utilizados para cumplir con su Parte del Costo.

Si usted no quiere una tarjeta de Medi-Cal para un mes pasado, es posible que usted pueda utilizar estos cobros médicos pasados, ya pagados o sin pagar, para cumplir con su Parte del Costo para obtener tarjetas de Medi-Cal actuales y futuras. A fin de hacer ésto, primero usted tiene que ser un beneficiario de Medi-Cal con una Parte del Costo en algún momento, antes de que se cumplan los seis meses, contados a partir de la fecha de esta notificación.

Sección B. LA OBTENCION DE TARJETAS DE MEDI-CAL ACTUALES Y FUTURAS

Si usted tiene una Parte del Costo ahora, esta sección es pertinente a usted.

EL USO DE COBROS MEDICOS PASADOS QUE NO HAN SIDO PAGADOS PARA CUMPLIR CON SU PARTE DEL COSTO PARA OBTENER UNA TARJETA DE MEDI-CAL ACTUAL O FUTURA.

Usted puede utilizar los cobros médicos pasados para cumplir con su Parte del Costo en el mes actual o en el futuro si:

- los cobros NO SE HAN PAGADO y
- usted SIGUE SIENDO RESPONSABLE de los cobros médicos.

Usted tiene que dar estos cobros médicos pasados, que no se han pagado, a su departamento de bienestar del condado durante el mes para el cual usted quiere su tarjeta de Medi-Cal. Si usted le da al departamento de bienestar del condado cobros que son más grandes que su parte del costo para el mes actual, se deberán utilizar los cobros para cumplir con su Parte del Costo para meses consecutivos futuros hasta que se agote.

Esto NO le proporcionará un pago en efectivo a usted. Usted recibirá un ajuste en su Parte del Costo del mes actual o futuro.

Sección C. LOS PROCEDIMIENTOS PARA UTILIZAR LOS COBROS MEDICOS PASADOS:

EL PROCEDIMIENTO PARA TRAMITAR Y REGISTRAR SUS COBROS MEDICOS PASADOS

Si usted es beneficiario de Medi-Cal y paga una Parte del Costo, usted recibe cada mes una forma de "Registro de los Costos del Cuidado de la Salud",(llamado MC177). Lleve esta forma y cualesquier cobros médicos pasados que usted desee utilizar para cumplir con su Parte del Costo a su trabajador de elegibilidad. Sólo su trabajador de elegibilidad o un representante del condado pueden llenar la forma para los cobros médicos pasados.

Para los cobros actuales que usted desee utilizar durante el mes actual, usted puede seguir obteniendo la firma de su proveedor en la forma de la Parte del Costo, como siempre lo ha hecho.

SU(S) COBRO(S) MEDICO(S) TIENE(N) QUE REUNIR LOS REQUISITOS

A fin de utilizar un cobro médico para cumplir con su Parte del Costo, éste tiene que mostrar:

1. El nombre y la dirección del proveedor que proporcionó el servicio.

2. Ya sea el número de identificación de Medi-Cal del proveedor, su número de identificación como contribuyente, o su número de licencia. (La mayoría de los cobros médicos muestran este número; si el suyo no lo muestra, pida a su proveedor que se lo escriba en el cobro.)
3. La(s) fecha(s) en que se proporcionó el servicio.
4. La clase de servicio proporcionado, incluyendo una clave de procedimiento, si el cobro se hizo después del 1 de enero de 1992.
5. El nombre de la persona que recibió el servicio.
6. La cantidad que usted actualmente le debe al proveedor.
7. La fecha del cobro. (Para los cobros médicos pasados que no han sido pagados, que usted desea utilizar para cumplir con su Parte del Costo, la fecha del cobro tiene que caer dentro del plazo de 90 días, contados a partir de la fecha en que usted le da el cobro a su departamento de bienestar del condado; este requisito no es pertinente a los cobros médicos pasados ya pagados que reúnen los requisitos para ser utilizados para cumplir con su Parte del Costo.)

Si un cobro médico pasado no contiene esta información, usted tiene que tratar de obtener una declaración adicional de su proveedor, que muestre esta información. Si usted no puede obtener esta información, su trabajador de elegibilidad tiene que ayudarle a obtener de su proveedor la información que falta. Si su trabajador de elegibilidad no puede obtener esta información, es posible que usted pueda proporcionar la información que falta haciendo una declaración bajo juramento.

Por favor dése por enterado que a fin de utilizar un cobro médico pasado para cumplir con su Parte del Costo, éste no pudo haber sido utilizado en relación a su Parte del Costo durante un mes anterior.

¿QUE TAN ANTIGUO PUEDE SER UN COBRO?

Generalmente, cuando un cobro tiene más de cuatro años, no puede utilizarse en relación a su Parte del Costo, puesto que, conforme a la ley, usted deja de ser responsable de una deuda tan vieja. Sin embargo, existen excepciones a la regla, y si usted aún sigue siendo responsable de este cobro médico pasado, bajo una de estas excepciones, es posible que su cobro médico pasado se pueda utilizar en relación a su Parte del Costo. En tanto que sea consistente con las leyes de California y la sección 337 del Código de Procedimientos Civiles, Medi-Cal considera que usted sigue siendo responsable del pago de un cobro médico de más de cuatro años de antigüedad, si usted demuestra que:

- En realidad el gasto médico tiene menos de cuatro años; **o**
- El gasto médico se ha reducido a un fallo del tribunal; **o**
- Existe un contrato que extiende la ley de prescripción para el gasto; **o**
- Se ha hecho un abono/pago parcial en relación al gasto durante los últimos cuatro años; **o**
- Existe un acuerdo para pagar el gasto; **o**
- Existe otro comprobante lógico que muestra que usted sigue siendo responsable del gasto.

LOS COBROS Y LOS ESTADOS DE CUENTA DE LAS TARJETAS DE CREDITO

Las relaciones de cobro de las agencias de cobranzas y, bajo ciertas condiciones, los estados de cuenta de las tarjetas de crédito pueden utilizarse como evidencia de gastos médicos. Tales estados de cuenta, ya sea por sí solos, o con un cobro médico de su proveedor, tienen que satisfacer los artículos del 1-7 en la sección anterior, titulada "Sus Cobros de Medi-Cal Tienen que Reunir los Requisitos", antes de que se puedan utilizar en relación a su Parte del Costo. Estos estados de cuenta también pueden llevarse a su trabajador de elegibilidad junto con su cobro médico de su proveedor para actualizar un cobro del proveedor o para mostrar la cantidad que se debe en el cobro.

SE LE INFORMARA A USTED COMO CORREGIR LOS COBROS MEDICOS PASADOS QUE SU CONDADO NO ACEPTO

Si su departamento de bienestar del condado decide que usted no puede utilizar un cobro médico pasado, en relación a su Parte del Costo, usted recibirá una notificación señalando la razón por la negación. Usted tendrá 10 días para corregir el problema y devolver el cobro al condado. Si usted no lo hace, recibirá una notificación de negación durante los próximos 30 días. En ella se le indicará la razón para la negación, y le aconsejará lo que usted tendrá que corregir antes que pueda devolver su cobro médico al condado.

En cuanto a los cobros médicos que han sido aceptados y utilizados en relación a su Parte del Costo, usted recibirá una notificación de aprobación.

¿TIENE PREGUNTAS?

Si usted tiene alguna pregunta sobre cómo funciona el programa de Parte del Costo de Medi-Cal, puede pedir ayuda a su trabajador de elegibilidad o llamar a su oficina local de servicios o asistencia legal.

El convenio en la demanda Hunt vs. Kizer no decidió si algunas cosas se pueden utilizar para cumplir con una Parte del Costo, como los cargos de financiamiento, préstamos, algunos cargos de las tarjetas de crédito y algunos gastos cuando usted tiene seguro. La demanda no decidió si los pacientes en cuidado a largo plazo pueden utilizar todos los procedimientos en esta notificación para cumplir con sus Partes del Costo.

GUARDE ESTA NOTIFICACION. El referirse a la misma le ayudará a cumplir con su Parte del Costo y a obtener tarjetas de Medi-Cal de ahora en adelante.

NOTIFICACION PARA UNA AUDIENCIA

- Si usted es una persona que reúne, reunía o pudo haber reunido los requisitos para recibir beneficios como persona necesitada bajo Medi-Cal, con una Parte del Costo determinada durante cualquier mes, o
- Si usted reunirá los requisitos para recibir Medi-Cal como persona necesitada y tendrá una Parte del Costo determinada en el futuro.

Sus derechos se verán afectados por el convenio de la demanda conocida como George Hunt, et al., vs. Kenneth Kizer, et al. La demanda sostiene, en parte que el Departamento de Servicios de Salud de California ha violado las leyes federales y los ordenamientos en su operación del programa de Medicaid para las personas necesitadas, conocido también como el Programa de Parte del Costo de Medi-Cal o Medi-Cal para personas necesitadas bajo Medi-Cal. Esta notificación contiene una descripción del convenio que resultó de esta demanda.

Los términos completos del convenio están en: *Clerk of the Court, United States Courthouse, 650 Capitol Mall, Sacramento, California 95814.*

El 19 de noviembre de 1993, a las 9:00 a.m., se llevará a cabo una audiencia en la Sala del Tribunal 1, de la Corte de Distrito de los Estados Unidos, *United States Courthouse, 650 Capitol Mall, Sacramento, California*, durante la cual el Tribunal decidirá si aprueba este acuerdo del convenio final.

Si está de acuerdo con este convenio, usted no tiene que hacer nada. Si usted no está de acuerdo con el convenio, tiene que escribir una carta a uno de los abogados de la demanda colectiva, explicando las razones por las cuales usted no está de acuerdo con el convenio que se propone. El nombre y dirección del abogado son:

Eugenie Denise Mitchell
Legal Services of Northern California
515 - 12th Street
Sacramento, CA 95814

Su carta tiene que llevar el matasellos de a más tardar el 5 de noviembre de 1993.

Si usted envia tal carta, usted o su abogado, actuando a nombre suyo, pueden presentarse en la audiencia y exponer cualquier evidencia o argumento relevante a la imparcialidad del convenio.

Cualquier miembro del grupo que no haga sus objeciones por escrito, de la manera mencionada anteriormente, deberá ser considerado como que renunció a tales objeciones, y para siempre se le privará del derecho de hacer cualquier objeción (por apelación u otro medio) al convenio propuesto.

Para mayores informes sobre el convenio, usted puede comunicarse con cualquiera de los siguientes abogados para los demandantes: Legal Services of Northern California oficina en Sacramento (916) 444-6760 (Sacramento) o llame gratis al (800) 468-8890 ext. 146 (Norte de California), u oficina regional Mother Lode (916) 823-7560 (Auburn) o llame gratis al (800) 660-6107 (Norte de California); Western Center on Law and Poverty, oficina de Los Angeles, (213) 487-7211; National Health Law Program, oficina de Los Angeles (310) 204-6010.

EXHIBIT C

OUTLINE OF HUNT ALL COUNTY WELFARE
DIRECTORS LETTER 93-63

OUTLINE OF HUNT ALL COUNTY WELFARE DIRECTORS LETTER 93-63

EXHIBITS ATTACHED TO ACWDL 93-63

EXHIBIT A

- TRANSMITTAL MEMO: FORMS AND INFORMATIONAL LETTER REQUIRED BY THE HUNT V KIZER LAWSUIT
- HUNT V KIZER MEDICAL BILLS APPROVED LETTER
- HUNT V KIZER FIRST DISAPPROVAL LETTER
- HUNT V KIZER SECOND DISAPPROVAL LETTER
- MC 1054 HK
- LETTER OF AUTHORIZATION
- RECORD OF MEDICAL BILLS SUBMITTED AND ACCEPTED FOR APPLICATION TOWARD SHARE OF COST --HUNT V KIZER

EXHIBIT B

- HUNT V KIZER BENEFICIARY NOTICE, "YOUR RIGHTS TO USE OLD MEDICAL BILLS TO MEET YOUR SHARE OF COST"

EXHIBIT C

- OUTLINE OF HUNT ALL COUNTY WELFARE DIRECTORS LETTER 93-63

EXHIBIT D (AVAILABLE TO COUNTIES ONLY)

- CAMERA READY COPY FOR HUNT V KIZER MEDICAL BILLS APPROVED LETTER, FIRST DISAPPROVAL LETTER, AND SECOND DISAPPROVAL LETTER

EXHIBIT D

CAMERA READY COPY FOR HUNT V KIZER MEDICAL BILLS APPROVED LETTER, FIRST DISAPPROVAL LETTER, AND SECOND DISAPPROVAL LETTER

Camera ready copies of the Hunt Medical Bills Approval Letter, First Disapproval Letter, and Second Disapproval Letter will be distributed to counties in a separate mailing.