## **DEPARTMENT OF HEALTH SERVICES**

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



October 31, 2001

Medi-Cal Eligibility Information Letter No.: I 01-14

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

LETTER OF AUTHORIZATION (Over One-Year Letter) MC 180-2 SHARE-OF-COST (SOC) FORM.

This letter is to transmit a copy of form MC 180-2 (8/98). The MC 180-2 is used with the Over One-year Eligibility Letter of Authorization (MC180) to record expenses used to meet a beneficiary's SOC during the time they should have been eligible for Medi-Cal.

The counties should fill out the section with four boxes near the top of the form and the section where the title reads "MEDI-CAL/DENTAL EXPENSES OF FAMILY MEMBERS LISTED BELOW MAY BE USED TO MEET SHARE OF COST." The providers should fill out the rest of the form; instructions for the providers are on the form itself (see enclosed copy).

If you have questions concerning this form, please contact Mr. Craig Yagi of my staff at (916) 657-1182.

Sincerely,

ORIGINAL SIGNED BY

Shar Schroepfer, Chief Medi-Cal Eligibility Branch

Enclosure

## ELIGIBILITY LETTER OF AUTHORIZATION • SHARE OF COST • RECORD OF HEALTH COST

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

## SHARE OF COST · RECORD OF HEALTH COST · MEDI-CAL OR COUNTY MEDICAL SERVICES PROGRAM

MONTH OF ELIGIBILITY	SHARE OF COST	COUNTY DISTRICT	EW FILE NO.
MONTH YEAR	THE AMOUNT YOU MUST \$ PAY OR OBLIGATE IS		

PLEASE READ THE DECLARATION BELOW:

PROVIDER INSTRUCTIONS AND DECLARATION: EACH SERVICE LISTED BELOW BY ME HAS BEEN PROVIDED BY ME TO THE PERSON LISTED ON THE DATE SPECIFIED. I HEREBY DECLARE THAT I RECEIVED PAYMENT OR WILL SEEK PAYMENT FROM THE PATIENT FOR THE AMOUNT IN THE "AMOUNT BILLED PATIENT" COLUMN AND THAT I WILL NOT SEEK OR ACCEPT PAYMENT FROM THE MEDI-CAL PROGRAM FOR THAT AMOUNT. I UNDERSTAND THAT THE AMOUNT REIMBURSED BY INSURANCE, MEDICARE OR ANY OTHER THIRD PARTY FOR THE SERVICE RENDERED CANNOT BE LISTED ON THIS FORM. I CERTIFY UNDER PENALTY OF PERJURY THAT THE INFORMATION I HAVE LISTED ON THIS FORM IS TRUE AND CORRECT. I UNDERSTAND THE LETTER OF AUTHORIZATION (MC-180) CANNOT BE ISSUED UNTIL THE SHARE OF COST FOR THIS MONTH IS PAID OR OBLIGATED BY THE BENEFICIARY.

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