
MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-354 - IMPROPER PAYMENT REPORT

PURPOSE & USE

This form is used by the Regional Office to report cases involving improper Medicaid payments due to Agency or client error. The form is submitted to the Medicaid Eligibility Division in the State Office. Refer to Section I, Improper Medicaid Benefits.

INSTRUCTIONS

Prepare an original and 1 copy. Exception: Prepare an original and 2 copies when the report is for a Medicaid eligible couple or two separate cases in the same family. The copy remains in the case record and the original is routed to the Medicaid Eligibility Division. The form should be typewritten when possible. If typing is not possible, please be sure the handwriting is legible. Each section of the form should be completed or notated as not applicable (NA). Extra sheets of paper may be used when there is not enough room on the form to fully explain.

Regional Office: Enter the Regional Office name.

1. Aged & Disabled Medicaid: Enter the name of the recipient, Medicaid ID number, and address. For an eligible couple, enter the name of the spouse also. Enter the name and address of the designated representative, if applicable.
2. Improper Payment Information: Enter the reason for the Improper Payment (check the applicable block) and the source of the information, such as IEVS hit, SVES, BENDEX, SDX, bank clearance, etc. Explain how this information was verified by independent verification. Enter the date of the last redetermination (or application or last contact with the client or representative as appropriate). In the space provided, summarize the events/cause of the improper payment. Include pertinent dates, such as the date(s) the changes occurred that caused the improper payment.

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3. Period of Time Covered by Improper Payment: Enter the beginning date (month/day/year) that the improper payment began. This is the date the change could have been effected had the change been reported timely or acted upon promptly. Also enter the ending date (month/day/year) of the improper payment.

Enter the client's coverage group for each improper payment period of time. In the space provided, enter the amount of Medicaid Income used and the amount Medicaid Income should have been (correct amount). Enter the coverage group in which eligibility remains for each improper payment period (if appropriate).

4. Action by Regional Office: Enter the effective date of closure via MEDS or the effective date of the corrective action via MEDS, whichever is applicable.
5. Resources Available for Recovery: Enter the client's income source(s) and amount(s) and list any and all resources available to the client.

Worker Signature/Date: The worker completing the form will sign and date here.

Supervisor Signature: The Medicaid Specialist Supervisor will sign here after reviewing the form.

Date: Enter the date the form is signed by the Supervisor.

3. PERIOD OF TIME COVERED BY IMPROPER PAYMENT:

The begin date of the improper payment is the date action could have been taken if the information had been promptly reported or acted upon:

Begin Date MM/DD/YY	End Date MM/DD/YY	Cov. Group in which ineligibility occurs	Medicaid Income Used	Correct Medicaid Income	Cov. Group in which eligibility remains
			\$	\$	
			\$	\$	
			\$	\$	
			\$	\$	
			\$	\$	
			\$	\$	
			\$	\$	
			\$	\$	

4. ACTION BY REGIONAL OFFICE

Effective date of case closure or correction: _____

5. RESOURCES AVAILABLE FOR RECOVERY

WORKER'S SIGNATURE _____ DATE _____

SUPERVISOR'S SIGNATURE _____ DATE _____