MEDICARE PREMIUM REPAYMENT CREDIT REPORT

ND DEPARTMENT OF HUMAN SERVICES

SFN 828 (9-2013)

Mail Check and Form(s) to:
ND DEPT. OF HUMAN SERVICES / FISCAL ADMINISTRATION
600 E. Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250

Clear Fields

Please complete separate form for EACH INDIVIDUAL case/program. You may submit one check for multiple cases/programs.

County Name:		Check Number:			
Client Name:		Amount of Check:			
County Number:	Case Number:	Amount Paid on this Claim (applicable only if payment is for multiple cases):			
Client ID Number:		The Privacy Act of 1974 requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is voluntary and it is requested for verification of client account information. Failure to disclose this information will delay the processing of the form.			
Social Security Number:					

Please complete program information for the case identified above.

☐ **Medicare Premium Repayment** - Month(s) being Repaid (See QIRS Screen): _____

Reason for Repayment: Repayment of Medicare Premium amount paid by the State when the recipient was eligible as a Qualifying Individual. This person is applying for other Medicaid benefits. Policy requires reimbursement of Qualifying Individual benefits prior to eligibility for other Medicaid benefits.

☐ **Workers with Disabilities Enrollment Fee** ☐ **Workers with Disabilities Premium Payment**

☐ **Children with Disabilities Premium Payment**

☐ **Healthy Steps Premium Repayment** - Month(s) being Repaid: _____

For Estate Recovery Collections, <u>check Yes or No for each program</u>. Refer to instructions to determine which program the funds are to be applied to. (Incomplete form along with the check will be returned for completion and resubmission)

4. Medicaid: ☐ Yes ☐ No	**1. Basic Care:** ☐ Yes ☐ No	**2. Expanded SPED:** ☐ Yes ☐ No	**3. Clawback** ☐ Yes ☐ No

☐ Estate Recovery Collection - Date of Death: _____

☐ Have prior funds been submitted for this client - Month(s) Submitted: _____

☐ Other Refund (Please complete the following):

Was this overpayment reported on Surveillance and Utilization Review Section Referral (SFN 20)? ☐ Yes ☐ No

Date of Service:	Amount Refunded:	Reason for Refund:

Completed By:	Telephone Number:	Date:

For state office use only:

Instructions for Completing Credit Form For Medicare Premium Repayment Medicaid / Basic Care / Expanded SPED / Clawback

Medicare Premium Repayment

Month(s) Being Repaid: List all months which recipient has repaid the Medicare Premium. Months listed should be the same as the months indicated on the QIRS screen in TECS.

Medicaid / Basic Care / Expanded SPED / Clawback

NOTE: **For Estate Recovery Collections - monies received are to be applied in the following order as applicable:**

1. Basic Care
2. Expanded SPED
3. Clawback
4. Medicaid

Therefore you will need to verify outstanding balances by program to determine which program monies are to be applied to. ***(Incomplete form along with check will be returned for completion).***

Instructions on verifying outstanding balances by program

VISION: Inquiry Option on Client Profile for: "Client Medicaid Benefits Paid"
"Client Expanded SPED Benefits Paid"
"Client Basic Care Benefits Paid"

Please attach copy of paid screen for Expanded SPED and/or Basic Care Estate Recovery collections.

TECS: **Option #4** on the "IEME MENU"
(Screen for outstanding Basic Care and/or Expanded SPED balances)
Please attach copy of paid screen for Expanded SPED and/or Basic Care Estate Recovery collections.

Option #2 on the "IEME MENU"
(Screen for outstanding Medicaid balances and Clawback balances)

Enter SSN (Required) field - - Enter

Check Yes or No for each program (Basic Care, Expanded SPED, Clawback, or Medicaid) and indicate if Estate Recovery Collection or Other Refund

Estate Recovery Collection: *Check this box to represent Estate Recovery and indicate date of death.*
Have prior funds been submitted for this client - Month Submitted *- Check this box and indicate the month(s) prior funds were submitted.*

Other Refund: Check this box if monies received represent refund other than Estate Recovery Collection
Identify date(s) of service and amount refunded
Reason for Refund: Indicate the reason for the refund or what caused an overpayment