

## REQUEST FOR PAYMENT/OVERRIDE FORM

**This form will be used for:**

- Request for Payment of Transition Intensive Support Coordination (TISC)
  Request for payment of Transition Services
  Request for Payment of Denied Claims

Participant Name: \_\_\_\_\_ Medicaid # (13 digits): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Agency Name: \_\_\_\_\_ Agency Phone: \_\_\_\_\_ Agency Fax: \_\_\_\_\_  
 Agency Contact: \_\_\_\_\_ Agency E-mail Address: \_\_\_\_\_

Population: Check One

COMMUNITY CHOICES WAIVER (CCW)
  ADULT DAY HEALTH CARE (ADHC) WAIVER
  OTHER: \_\_\_\_\_

Reason for Request: \_\_\_\_\_

PA Request is for: Begin Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ **Initials Only:** Date Support Coordination Agency Received the Medicaid Decision Notice: \_\_\_\_/\_\_\_\_/\_\_\_\_

**ATTACH ONLY THOSE DOCUMENTS NECESSARY TO JUSTIFY REQUEST:** (DHH may request additional information.)

Check the appropriate boxes below that contains documents that are attached:

- Approved POC
  Progress Notes/Typed Chronology
  CMS 1500 (completed)
  Other: \_\_\_\_\_

**DHH WILL NOT OVERRIDE TIMELY FILING LIMITS.** IT IS THE RESPONSIBILITY OF EACH AGENCY TO RECONCILE ALL BILLINGS IN A TIMELY MANNER. DHH WILL REQUIRE A MAXIMUM OF FORTY-FIVE (45) CALENDAR DAYS TO PROCESS ALL REQUESTS AFTER RECEIPT OF ALL REQUIRED DOCUMENTATION. ANY REQUEST NOT CONTAINING THE NECESSARY INFORMATION WILL BE RETURNED AS INCOMPLETE AND CONSIDERED NOT RECEIVED.

**TO BE COMPLETED BY OAAS:**

- APPROVED
  DENIED
  RETURNED (See Reason Below)

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 If denied or returned, please provide reason below:  
 \_\_\_\_\_  
 \_\_\_\_\_

OAAS Authorized Reviewer Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY DHH/MEDICAID PROGRAM SUPPORTS AND WAIVERS (MPSW), if applicable:**

- APPROVED
  DENIED
  RETURNED (See Reason Below)

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 If denied or returned, please provide reason below:  
 \_\_\_\_\_  
 \_\_\_\_\_

DHH/MPSW Authorized Reviewer Signature \_\_\_\_\_ Date \_\_\_\_\_

## INSTRUCTIONS FOR COMPLETING REQUEST FOR PAYMENT/OVERRIDE FORM

### Step One - Indicate Reason for Use of Form

- 1.) **Request for Payment of Transition Intensive Support Coordination (TISC)** – Use form to request payment for TISC services for up to four months prior to the individual transitioning out of a nursing facility.
- 2.) **Request for Payment of Transition Services** – Use form to request payment of funds expended by a designated purchaser prior to learning a participant will be unable to transition back into the community with a waiver opportunity..
- 3.) **Request for Payment of Denied Claims** – Use form to request payment of claims denied by Molina.

### Step Four - PA Request Dates

Indicate the start and end date for the period of reimbursement you are requesting.

### Step Two - Complete Demographic and Support Coordination Agency Information

**Do not leave any blanks.** Indicate the waiver or other population the request is for.

### Step Three - Reason for Request

**Be specific.** For “Request for Payment of Denied Claims”, indicate the reason for the request and include the 3 digit Medicaid claim denial code from the Remittance Advice, i.e., observation services could not be completed because services did not begin until after the quarter, **indicate what services did not begin in that quarter and the date the services did begin (this is needed so the PA for the provider can be canceled for that period)**, Denial Code 191

### Step Seven - First Signature Block

**To be completed by OAAS Regional Office (R.O.)** - Support coordinator agency will submit completed form and supporting documentation to OAAS R.O. for approval and signature. If denied or returned, the OAAS R.O. will give a detailed explanation for rejection, using an extra sheet if necessary. If approved, OAAS R.O. will e-mail a copy to the support coordination agency, a copy to SRI [ljarrrett@statres.com](mailto:ljarrrett@statres.com) for payment, and a copy to [Becky.Palmer@la.gov](mailto:Becky.Palmer@la.gov) at OAAS State Office (S.O.).

### Step Eight - Second Signature Block

**TO BE USED BY DHH/MEDICAID PROGRAM SUPPORTS AND WAIVER (MPSW) SECTION, WHEN APPLICABLE.**