FACT SHEET FOR REIMBURSEMENT OF PAID MEDICAL OR DENTAL BILLS

NYC Human Resources Administration Department of Social Services

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In order for the Medical Assistance Program to evaluate your reimbursement request for paid medically related expenses, the following documentation is required:

1. **Medical and Dental Bills** - All paid medical and dental bills must be the originals (photocopy of the front **and** the back of checks) and include:

   - Patient's name, address, MA number or PA number, and Social Security number
   - Diagnosis for which service was rendered
   - Date of each medical or dental service
   - Cost of each medical or dental service
   - A detailed description of each medical or dental service rendered and procedure code

NOTE: If the service was for anesthesiology or psychiatry, the number of minutes of treatment must be shown. If the service was for therapy, the length of the session and whether it was individual or group is to be indicated. For nursing services, include the level of care - RN or LPN, license number(s), and the number of hours/days per week.

Proof Of Payment

- Name, address, Tax I.D. #, and telephone number of physician or dentist
- **Proof of payment** for each medical or dental service **and** an explanation why payment was not made through Medicaid
- If you have Medicare or other health insurance, a statement from the insurer that lists the amount reimbursed or that the bill has been disallowed

In addition, all paid dental bills must include:

- Type and number of radiographs
- Design and materials utilized
- Root canal therapy: tooth involved, number of canals filled
- Fillings: amalgam or composite, tooth involved, number of surfaces
- A detailed description of the procedure if the service rendered presented a special problem

2. **Drug or Appliance Bills** - All paid Medicaid reimbursable drug and appliance bills must include:

   - Name, address, and telephone number of the ordering physician or dentist
   - Date of the purchase
   - Name of the drug, medication or appliance
   - Manufacturer's name
   - Quantity or count prescribed
   - Cost of the prescription or appliance

Mail the documentation to the Medical Assistance Program, Reimbursement Unit, 330 W. 34th Street, 9th Floor, New York, N.Y. 10001. Be sure to include your Medicaid Client Identification Number (CIN) or Social Security Number **and** an explanation of why Medicaid was not used. Keep copies of all materials you send. If there are any questions, call (212) 643-3386.

NOTE: If you are in receipt of Home Care Services (except Private Duty Nursing), mail documentation to Home Care Services Program, Bureau of Home Care Operations, 309 E. 94th Street, New York, N.Y. 10128.