

Ohio Department of Medicaid  
**CHANGES IN MEDICAID HEALTH CARE COVERAGE DATE AND MEDICARE BUY-IN ELIGIBILITY**

**Consumer Information**

\*This request is an emergency?  Yes or  No

*County Name	*County No.	*Date
*Consumer's First Name	*Consumer's Last Name	
*Date of Birth	*Case Number	
SSN	*Billing Number from IQIM	
Claim Number from Medicare Card		

**Section I**

**Health Care Date Change:**

1.  In accordance with Ohio Administrative Code, the CDJFS is hereby authorizing a change in the health care date for this consumer.
- a. Category of medical assistance \_\_\_\_\_ (e.g. MA L, MA D, MA P)
  - b. Med Class from IQEL \_\_\_\_\_ (e.g. HYFAM, NCLIF, BGPCY)
  - c. Sequence \_\_\_\_\_ (e.g. 01, 02)
  - d. Eligibility should be backdated beginning \_\_\_\_\_ (mm/dd/yy) and ending \_\_\_\_\_ (mm/dd/yy).

**Spenddown:**

2.  In accordance with the Ohio Administrative Code, this consumer is eligible for Medicaid through the spenddown process. The spenddown was met for the following dates (dd/yy).
- a. Category of medical assistance \_\_\_\_\_ (e.g. MA A, MA B, MA D)
  - b. Sequence \_\_\_\_\_ (e.g. 01, 02) for:
 

Jan. _____	April _____	July _____	Oct. _____
Feb. _____	May _____	Aug. _____	Nov. _____
March _____	June _____	Sep. _____	Dec. _____

**Additional Information (Required):**

This consumer is also eligible for a Medicare Premium Assistance Program (MPAP) for the specified time period in this section as \_\_\_\_\_ (e.g. QMB, SLMB, QI-1, QWDI, N/A).

This consumer has other health insurance for the specified time period in this section.  Yes or  No  
 Have you documented the health insurance coverage in AEFMC?  Yes or  No

**Section II Medicare Buy-In Eligibility**

1.  In accordance with the Ohio Administrative Code, this consumer is eligible for the Medicare Buy-In Program under category of medical assistance:
- QMB effective date \_\_\_\_\_ (mm/dd/yy)
  - SLMB effective date \_\_\_\_\_ (mm/dd/yy)
  - QI-1 effective date \_\_\_\_\_ (mm/dd/yy)
  - QWDI effective date \_\_\_\_\_ (mm/dd/yy)
  - MA \_\_\_\_\_ effective date \_\_\_\_\_ (mm/dd/yy)
2.  This consumer is no longer eligible for Medicare Buy-In effective \_\_\_\_\_ (mm/yy).

**Section III Medicare Date Change**

Please update the Medicaid claims payment system to reflect the correct Medicare Part A/B eligibility span for this consumer.

Medicare Part A effective date: \_\_\_\_\_ "(mm/yy)  Medicare Part A end date: \_\_\_\_\_ (mm/yy)

Medicare Part B effective date: \_\_\_\_\_ "(mm/yy)  Medicare Part B end date: \_\_\_\_\_ (mm/yy)

**Section IV**

\* CLRC notes documented  Yes  No

Reason for request:

**Section V**

\* Caseload No. \_\_\_\_\_

* Worker First Name	* Worker Last Name	*Phone (Direct line in case of questions)
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* Supervisor First Name	* Supervisor Last Name	*Phone (Direct line in case of questions)
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\* Do you have approval to submit this form directly to Medicaid for processing?  Yes  No