SPEND DOWN NOTIFICATION

PURPOSE: To provide the participant with an official notification after they have submitted incurred medical expenses to meet spend down. This form should be used to notify a participant when incurred medical expenses meet the spend down expense, and when additional incurred medical expenses or a payment to MO HealthNet Division is required to meet spend down; and when submitted incurred medical expenses cannot be used to meet spend down expense, including the reason the incurred medical expenses were not allowed.

NUMBER OF COPIES AND DISPOSITION: Within two business days of the date that the incurred medical expenses are received, complete the IM-29 (SPDN). Make at least two copies. Mail one copy to the participant, and file one copy in the case record.

NOTE: When the participant has an Authorized Representative an additional copy should be mailed to the representative.

MANUAL REFERENCE:

0810.000.00 MO HEALTHNET COVERAGE
0810.010.15 MEETING SPEND DOWN WITH INCURRED EXPENSES

INSTRUCTIONS FOR COMPLETION: Complete this form using on line forms template.

FSD OFFICE: Enter the name of the Family Support Division Office.

TELEPHONE NUMBER: Enter the telephone number of the FSD Information Center or the telephone number of the FSD office.

DATE: This field is pre-populated with the date the form is created.

FSD OFFICE ADDRESS: Enter the address of the FSD office.

NAME: Enter the name of the person to whom the letter is sent.

ADDRESS: Enter the address the letter will be sent to.

CITY, STATE, ZIP CODE: Enter the city, state and zip code the letter will be sent to.

CASE NAME AND CASE NUMBER: Enter the head of household name and Departmental Client Number (DCN.)

MO HEALTHNET ELIGIBLE INDIVIDUAL(S) AND DCN: Enter the name(s) of the MO HealthNet individuals on the case who are eligible for MO HealthNet Spend down coverage and the individual's DCN

Page 2

CHECK BOX: Check this box if the participant(s) has met spend down.

MONTH: Enter the month the participant and/or spouse has provided incurred medical expenses to meet spend down.

MO HEALTHNET COVERAGE START DATE: Enter the date the participant met spend down with incurred medical expenses.

MONTHLY SPEND DOWN AMOUNT: Enter the amount of spend down that corresponds with the month entered in the previous column.

AMOUNT OF SPEND DOWN MET ON START DATE: Enter the amount of the participant's liability on the date spend down is met.

CHECK BOX: Check this box if the participant and/or spouse has provided incurred medical expense or a partial payment and has not met spend down.

MONTH: Enter the month the participant and/or spouse has provided incurred medical expenses and has not met spend down.

SPEND DOWN AMOUNT: Enter the amount of spend down that corresponds with the month entered in the previous column.

ALLOWABLE MEDICAL EXPENSES PROVIDED: Enter the allowable medical expenses provided by the participant.

PROVIDER NAME: Enter the name of the provider of services.

PARTIAL PAYMENT PROVIDED: Enter the amount of the partial payment received by MHD.

AMOUNT OF SPEND DOWN EXPENSE REMAINING FOR THE MONTH: Enter the amount of expenses remaining to meet spend down for the month.
PLEASE PROVIDE COPIES OF PAID AND OR UNPAID BILLS …: Enter a date which allows the participant 10 days to provide copies of paid and/or unpaid bills/receipts, etc.

CHECK BOX: Check this box if the participant provided bills, but they were not used to meet spend down.

MONTH: Enter the month the participant and/or spouse has provided incurred medical expenses that cannot be used to meet spend down.

Page 3

DATE OF BILL: Enter the date the service was provided for the incurred expenses the participant and/or spouse has provided that cannot be used to meet spend down.

PROVIDER: Enter the name of the provider of the services for the incurred expenses that cannot be used to meet spend down.

REASON: Enter the reason the incurred medical expenses provided cannot be used to meet spend down.

TO SEE IF YOU CAN GET FREE LEGAL SERVICES CALL: Enter the phone number of the Regional legal aid office for the local FSD office.

ELIGIBILITY SPECIALIST: Enter the name of the Eligibility Specialist responsible for sending the form.

LOAD: Enter the caseload number of the Eligibility Specialist sending the form.

TELEPHONE NUMBER: Enter the telephone number of the FSD information Center or the telephone number of the FSD office.

CASE NAME AND DCN: Enter the head of household name and DCN.

SPOUSE AND DCN: Enter the name and DCN of the head of household's spouse who is included in the eligibility determination.

MONTH: This field is completed by the participant. The participant enters the month(s) payment should be applied.

AMOUNT OF SPEND DOWN EXPENSE REMAINING FOR THE MONTH: This field is completed by the participant using the AMOUNT OF SPEND DOWN EXPENSE REMAINING IN THE MONTH information from page 1.

AMOUNT PAID: This field is completed by the participant. The participant enters the amount of payment submitted to MHD Premium Payment for the designated month.

TOTAL: Total amount of payment sent to MHD.

AMOUNT OF EXCESS MEDICAL EXPENSES: Participant enters the amount of unpaid medical expenses exceeding the month's spend down amount and are **NOT** subject to payment by another source.

MONTH UNPAID MEDICAL EXPENSES INCURRED: Participant enters the month the medical expenses were incurred.

Page 4

MONTH TO APPLY EXCESS UNPAID MEDICAL EXPENSES TO SPEND DOWN: Participant designates the month (up to 3 succeeding months) which to apply medical expenses incurred from prior months month that are currently owed by the participant.

SIGNATURE OF PARTICIPANT OR AUTHORIZED REPRESENTATIVE:
Head of household or the authorized representative signs the form.

DATE: The participant or authorized representative signs the form.

SIGNATURE OF SPOUSE OR AUTHORIZED REPRESENTATIVE:
Spouse of head of household or the authorized representative signs the form.

DATE: The spouse or authorized representative signs the form.

IN THE ENVELOPE SECTION:

Eligibility Specialist enters the address of the participant.