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|  | | | | | | | MISSOURI DEPARTMENT OF SOCIAL SERVICES  FAMILY SUPPORT DIVISION  **POST ELIGIBILITY MEDICAL EXPENSE BUDGETING REQUEST** | | | | | | | | | | | |
| **FROM** | | | | | | | FSD STAFF | | TELEPHONE NUMBER     -   - | | | | | | DATE  01/22/2020 | | | |
|  | | | | | | | OFFICE ADDRESS (STREET, CITY, STATE, ZIP CODE)       , | | | | | | | | | | | |
| **TO** | | | | | | | NAME | |  | | CASE NAME | | | | | | | |
|  | | | | | | | ADDRESS (STREET) | |  | | CASE NUMBER | | | | | | | |
|  | | | | | | | CITY, STATE ZIP CODE | |  | | TELEPHONE NUMBER     -   - | | | | | | | |
|  | If you reside in a nursing home and are required to pay a surplus you may request to have your surplus reduced to allow you to pay for unpaid medical expenses that were incurred within the three months prior to your approved application for vendor coverage. This is referred to as Post Eligibility Medical Expense (PEME) budgeting. **This form is only required if you authorize the nursing facility where you reside to request PEME budgeting on your behalf.**  To be used to reduce your surplus, the medical expenses must be:   * Unpaid, * Medically necessary, and * Incurred no earlier than the three months prior to your approved application for vendor coverage.   Examples of allowable expenses include charges from the nursing home, doctor or hospital visits, prescriptions, or lab services.  To request Post Eligibility Medical Expense budgeting on your MO HealthNet Vendor case, please provide receipts or bills for unpaid medical expenses that verify the following:   * Name of patient, * Date of service, * Type of service(s) provided, * Charge for service(s) provided, * Amount of third party liability, and * Amount that you are responsible to pay.   **Authorization for the Nursing Facility Administrator to Represent You**  The nursing facility where you reside can assist you in making the request for Post Eligibility Medical Expense budgeting, but they must have your permission to do so. If you would like the nursing facility where you reside to help you make this request, please check the following box and list the facility administrator’s name. | | | | | | | | | | | | | | | | |  |
|  |  | | I | |  | | | authorize | | | | |  | | | | |  |
|  |  | |  | | Print Your Name | | |  | | | | | Name of Facility Administrator | | | | |  |
| Facility Name | | | Facility Address | | | | |
|  | to file a Post Eligibility Medical Expense request on my behalf, for the purpose of determining eligibility to have my surplus reduced to allow me to pay for unpaid medical expenses. | | | | | | | | | | | | | | | | |  |
|  | If the nursing facility administrator has your permission to do so, the administrator can represent you during the appeal process if your Post Eligibility Medical Expense budgeting request is denied. Check the box next to the following statement and identify the administrator of the facility where you reside to authorize the administrator to represent you throughout the appeal process. | | | | | | | | | | | | | | | | |  |
|  |  | | I | |  | | | authorize | | | | |  | | | | |  |
|  |  | |  | | Print Your Name | | |  | | | | | Name of Facility Administrator | | | | |  |
|  |  |  | |  | | | |  | | | |  | | | | | |  |
|  |  |  | | Facility Name | | | |  | | | | Facility Address | | | | | |  |
|  | to represent me and/or file an appeal on my behalf regarding the denial of my Post Eligibility Medical Expense budgeting request. | | | | | | | | | | | | | | | | |  |
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|  |  | | | | | | | | | | | | | | | | |  |
|  | My signature below certifies under penalty of perjury that all declarations made in this request are true, accurate, and complete. | | | | | | | | | | | | | | | | |  |
|  | | | | | |  | | | |  | | | |  | |  |  | |
|  | | | | | | SIGNATURE – APPLICANT/PARTICIPANT | | | |  | | | | DATE SIGNED | |  |  | |
|  | | | | | | LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE | | | |  | | | | DATE SIGNED | |  |  | |