



Important Information!

You may qualify for reimbursement

Sometime between December 9, 2008, and January 31, 2009, there was an error with the Oregon Health Plan (OHP) computer system. You or someone in your household has been identified as one of the people affected by this error.

Due to this error, your provider may not have been able to see:

- If you were eligible for OHP; or
- What medical services you qualified for under OHP.

The mistake has been corrected, but during this time, you may have paid for copayments or medical services when you should not have.

You may qualify for reimbursement

If you paid for services in error between December 9, 2008, and January 31, 2009, DHS may be able to pay you back.

This announcement is NOT a guarantee of payment. DHS will determine if you qualify for reimbursement.

You may qualify for reimbursement if you or someone in your household:

- Received medical services between December 9, 2008, and January 31, 2009; **and**
- Were affected by the computer system error; and as a result
 - Had to pay a **copayment**; or
 - Had to pay for **medical services**, including prescription medications.

Copayments

Call Client Services at 1-800-273-0557 if you paid a copayment you should not have. You will not have to provide proof. Have the following information ready:

- The name and medical care ID number of the person who received the service;
- The date the received the medical service was received; and
- The provider's name.

Medical service payments

If you paid for medical services other than a copayment, you will need proof of payment. Proof can be a receipt or invoice and must show:

- The date of the medical service;
- Your or the patient's name;
- The provider's name; and
- The amount you paid.

Mail or fax your proof of payment to:
DMAP Client Services
Att: Disenrollment/Reimbursement
500 Summer St. NE, E-44
Salem, OR 97301-1077
Fax: 503-945-6898

Be sure to include:

- The name and medical care ID number of the person who received the medical service;
- Your name, address and phone number.

What if I don't have proof?

If you do not have proof of payment, you can give the enclosed form to your provider. Your provider can fill out the information. You or your provider can mail or fax the completed form to the address or number listed on the form.

If your provider does not want to fill out the form, you can also ask for:

- A new receipt or invoice;
- A canceled check or copy of another form of payment;
- Claim forms; or
- A note from your provider.

Unpaid medical bills

If you have any medical bills you feel you have received in error, call Client Services at 1-800-273-0557. DHS will determine who is responsible for the bills.

Deadline: September 30, 2009

If you think you may qualify for reimbursement, you have until Wednesday, September 30, 2009, to contact Client Services. DHS will not process any requests for reimbursements received after this date.

Client Services will contact you

Please allow four to six weeks for DHS to determine if you qualify for reimbursement and to process the check. Client Services will send you a letter telling you if you qualify for reimbursement.

If you disagree with the decision, you have the right to ask for a hearing. You will have 45 days from the date of the letter to do this. You must use the Administrative Hearing Request form (DHS 443). You can get this form at any DHS office.

Tell your worker if you move

If you move, be sure to give your new address to your worker so DHS knows where to send your check.

Questions

- If you have any questions about this announcement, call Client Services at 1-800-273-0557, Monday through Friday, 8 a.m. to 4:30 p.m. Do not call your managed care plan.
- Call your worker if you need this information in another language or different format.



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OHP Clients: Only use this form if you do **not** have any other proof of payment, such as a receipt or invoice.



Proof of Payment Form

Dear OHP Provider,

Due to a computer system defect, your patient may have been disenrolled from their managed care plan in error or you may not have been able to verify the eligibility of your patient. As a result, your patient may have paid for services that should have been covered by the Oregon Health Plan.

Please provide the following information to help DHS determine if your patient qualifies for reimbursement. If more than one service was provided, please use the space available on the second page of this form. Please use a separate form for different patients

Note: For your patient to receive reimbursement, DHS must receive the Proof of Payment form no later than **September 30, 2009**.

Provider name:	
Provider ID #:	
Provider contact name:	
Phone:	
Fax:	
Patient's name:	
Patient's medical care ID #:	
Date of service:	
Medical service provided:	
Amount paid by patient:	

Please mail or fax this form to: Department of Human Services DMAP Client Services Unit Attn: Disenrollment/Reimbursement 500 Summer St. NE, E-44 Salem, OR 97301-1077 FAX – (503) 945-6898	To be completed by the patient or authorized representative: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Contact Name:</td> <td></td> </tr> <tr> <td>Contact Number:</td> <td></td> </tr> <tr> <td>Mailing address:</td> <td></td> </tr> <tr> <td>City, State, Zip:</td> <td></td> </tr> </table>	Contact Name:		Contact Number:		Mailing address:		City, State, Zip:	
Contact Name:									
Contact Number:									
Mailing address:									
City, State, Zip:									

Questions?

If you have any questions about completing this form, please call Provider Services at 1-800-336-6016, 7 a.m. to 4:30 p.m., Monday through Friday.

Additional services provided:

Provider (if different):	
Date of service:	
Medical service provided:	
Amount paid by patient:	
Provider (if different):	
Date of service:	
Medical service provided:	
Amount paid by patient:	
Provider (if different):	
Date of service:	
Medical service provided:	
Amount paid by patient:	
Provider (if different):	
Date of service:	
Medical service provided:	
Amount paid by patient:	
Provider (if different):	
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Provider (if different):	
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Amount paid by patient:	