

471-000-79 Form EA-160, "Record of Health Cost – Share of Cost – Medicaid Program", and Completion Instructions

Use: Form EA-160. "Record of Health Cost – Share of Cost – Medicaid Program," is used to record services, paid or obligated, that have been provided to a client in a specified month.

Form EA-160 advises the provider that the client is eligible for medical assistance, but before payment of medical services is approved, the client must pay or obligate his/her share of cost on medical services or supplies.

The medical provider signs Form EA-160 agreeing that s/he accepts the amount of the share of cost as the client's obligation. The provider returns the signed Form EA-160 to the Department of Health and Human Services Finance and Support Claims Processing Unit, along with the billing document, if the share of cost has been met.

Number Prepared: Form EA-160 is completed in triplicate on NCR paper.

Completion: Fields 1 and 2 are completed at local HHS office; the provider(s) complete Field 3. The client completes Field 4; and Field 5 is completed by the Claims Processing Unit.

PROVIDERS COMPLETE FORM EA-160 AS FOLLOWS:

Note: If the client's total share of cost of the claims listed in Field #3 meets or exceeds the Share of Cost listed in Field #1, Form EA-160 should be accepted as proof that the client's excess obligation has been met and that the client is thereby eligible for Medicaid.

FIELD #3:

Medicaid ID Number: Enter only medical/dental expenses for family members listed on the top of the form. Enter the 11-digit Medicaid ID number that corresponds to the family member(s) receiving services. Some clients, such as parents of Medicaid-eligible children or spouses of Medicaid-eligible clients who are aged or disable, will not be Medicaid-eligible, but their medical expenses count toward the share of cost.

Medicaid Provider Number: If you are a Nebraska Medicaid provider, enter your 11-digit number in the box labeled "MEDICAID PROVIDER NUMBER". If you are not a Medicaid provider enter your license number or Federal tax number.

Procedure/RX #: Complete with appropriate information/code.

Service Dates: The "SERVICE DATE" boxes should be completed with the date the service was provided.

Service Description: Enter a brief description of service.

Provider Name: Enter the name of the provider.

Provider Signature or authorized Rep: Complete with the signature of the provider or authorized representative and date. A signature stamp or typewritten signature will be accepted.

Total Billed: Enter the total bill including insurance.

Clients Share of Cost: Do not include in the "Client's Share of Cost" box the amount to be reimbursed by insurance or any third party including Medicare, for the service rendered. The client share of cost is the amount the client is responsible for the service rendered. It should not exceed the "Share of Cost" amount shown at the top of the form.

The provider is to complete all items to avoid delay in processing or rejection of the form by Nebraska Medicaid. If the client needs additional forms to meet their share of cost, you may supply them if you have them on hand or contact the local HHS office for additional forms. If there are questions about how to complete this form, the provider may call Medicaid Inquiry at 1-877-255-3092.

Distribution: The provider submits the white copy of this form with the billing document if the share of cost has been met, or mail separately if a billing document is not appropriate to: Department of Health and Human Services Finance and Support, P.O. Box 95026, Lincoln, Nebraska 68509, Attention: Claims Processing.

INSTRUCTIONS FOR THE CLIENTS:

1. When you receive this form, read and sign it, and take it to medical providers as you receive medical services in the month noted in Field #1. Keep the pink copy for your records and proof that your cost share has been met for the month in question. The provider who provides the last service necessary to meet your share of cost will send the white copy to HHS and keep the gold copy for his/her records.
2. For services that you received before this month, DO NOT USE THIS FORM.
3. For services received this month, either have your provider fill out this form or attach medical bills to this form.
4. At the top of the other side of this form in Field #1, there is a box labeled "SHARE OF COST". The amount shown in this box is the amount you must pay your provider(s) or agree to pay toward your medical/dental bills before Medicaid will pay. Medical expenses for any family member shown on this form can be used to meet the share of cost. DO NOT SEND CASH OR CHECKS TO THE LOCAL OFFICE OF THE NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES.
5. Take this form to any provider from whom you receive necessary medical/dental services (e.g. doctor, dentist, pharmacist, hospital, etc.) in the month specified. The provider will fill in the amount you have paid or have agreed to pay. YOU SHOULD NOT PAY OR AGREE TO PAY MORE THAN THE AMOUNT SHOWN IN THE "SHARE OF COST" BOX. YOU ARE RESPONSIBLE FOR THE ENTIRE AMOUNT SHOWN IN THE "CLIENT SHARE OF COST" COLUMN. Once the share of cost is met, allow the provider to mail the white copy of the form to the Department of Health and Human Services.

6. If all the provider boxes on this form have been used and you have not paid or obligated your share of cost, contact your case worker for more forms.
7. When you have met your "share of cost", it is your responsibility to let medical provider(s) know that you are Medicaid qualified. Use your copy of this completed form to show providers that you have met your share of cost and are Medicaid qualified for the month listed in FIELD #1. (NOTE: Medical claims will not be accepted until this form has been processed and case eligibility updated.)
8. If you have any questions about this form, contact your case worker.

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MANUAL LETTER # 12-2004

NEBRASKA HHS FINANCE
AND SUPPORT MANUAL

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Department of Health and Human Services Finance
and Support
P.O. Box 95026
Lincoln, NE 68509
Attention: Claims Processing

**RECORD OF HEALTH COST -
SHARE OF COST - MEDICAID PROGRAM**
Nebraska Health and Human Services System

Month of Eligibility
Month _____ Year _____

Share of Cost (Excess - Income) The amount you must pay or obligate is \$ _____	Replacement Form	
	YES	NO

FIELD #1

Client Address:

[Empty box for Client Address]

Local Office / Phone / Caseworker
[Empty box for Local Office / Phone / Caseworker]

FIELD #2

MEDICAL/DENTAL EXPENSES OF FAMILY MEMBERS LISTED BELOW MAY BE USED TO MEET SHARE OF COST

Medicaid ID # (A)	Name	Birthdate Mo. Day Year	Sex	SSN	HIC or RR #	INS

PLEASE READ THE INSTRUCTIONS ON THE BACK BEFORE COMPLETING.

DECLARATION OF PROVIDER: Each service listed below has been provided by me to the person listed on the date specified. I, the signed provider, hereby declare that I received payment from the patient for the amount shown in the "Client's Share of Cost" column and that I will not accept payment from Medicaid for that amount. I also understand and agree that I may seek payment from Medicaid for the costs of my services in excess of the amount billed to the patient, up to the Medicaid reimbursement rate. I understand that the amount to be reimbursed by insurance or any other third party, including Medicare, for the service rendered cannot be listed on this form. I certify under penalty of perjury under the laws of the State of Nebraska that the foregoing is true and correct. (See back for example)

FIELD #3

1	Medicaid ID Number (SEE (A) Above)	Provider Medicaid Number	Procedure/RX #	Service Dates						Service Description	
				From Month	Day	Year	To Month	Day	Year		

FIELD #4

I have read the instructions on the reverse side of this form. I agree to assume full legal responsibility for the amounts listed in the "Client's Share of Cost" column.

X _____ / /
Signature of Client or Responsible Party Date Signed

FIELD #5

FOR STATE USE ONLY	Date of Certification Month _____ Day _____ Year _____	Replace
	Reviewed By _____	Trans. _____

INSTRUCTIONS FOR RECORD OF HEALTH SHARE OF COST FORM

INSTRUCTIONS TO PROVIDER:

Use this Share of Cost form to record services, paid or obligated, which have been provided to clients (see below, example FIELD #3), in the CURRENT MONTH ONLY, the month listed in FIELD #1 or attach a medical bill that provides the same information.

EXAMPLE	Medicaid ID Number (SEE (A) Above) (1)	Provider Medicaid Number (2)	Procedure/RX # (3)	Service Dates (4)						Service Description (5)
	5 0 5 0 5 5 5 5 0 2	47054123400	99212	From Month 01	Day 05	Year 97	To Month 01	Day 05	Year 97	OFFICE VISIT
	Provider Name Dr. Anne Smith	Provider Signature or Authorized Rep <i>Dr. Anne Smith</i>	Date 01 30 97	Total Billed \$ 35.00			Clients Share of Cost \$ 35.00			

1. Enter only medical/dental expenses for family members listed on the top of the form. Enter the Medicaid ID number which corresponds to the family member(s) receiving services. Some clients such as parents of Medicaid children or spouses of Medicaid aged or disabled will not be Medicaid eligible but their medical expenses count toward the share of cost.
2. If you are a Nebraska Medicaid provider, enter your 11-digit number in the box labeled "MEDICAID PROVIDER NUMBER", if you are not a Medicaid provider enter your license number or Federal tax number.
3. Enter information in both the "PROCEDURE/RX #" and "SERVICE DESCRIPTION" boxes. Each service/prescription must be on a separate line. Additional forms may be obtained from the local HHS office.
4. The "SERVICE DATE" boxes should be filled in with the date the service was provided, see example above.
5. Brief description of service.
6. Provider Name.
7. Signature of provider or Authorized representative may sign. A signature stamp or typewritten signature will be accepted.
8. The total of the "TOTAL BILLED" is total bill including insurance.
9. Do not include in the "CLIENT'S SHARE OF COST" box the amount to be reimbursed by insurance or any third party including Medicare, for service rendered. The client share of cost is the amount the client is responsible for the service rendered, it should not exceed "Share of Cost" amount shown at the top of the form.
10. Please complete all items to avoid delay in processing or rejection of the form by the State. If the client needs additional forms to meet their share of cost, you may supply them if you have them on hand or contact the local HHS office for additional forms.
11. Please submit the white copy of this form with your billing document if the Share of Cost has been met, or mail separately if a billing document is not appropriate. Department of Health and Human Services Finance and Support, P.O. Box 95026, Lincoln, Nebraska 68509, Attention: Claims Processing.
12. If you have any questions about how to complete this form call Medicaid Inquiry at 1-800-332-0265, ext. 3154. Monday, Wednesday and Friday, 9:00 - 12:00 or 1:00 - 4:00 Central standard time.

INSTRUCTIONS FOR THE CLIENT:

1. When you receive this form, read and sign it, take it to medical providers as you receive medical services in the month noted in FIELD #1. Keep the pink copy of your records and proof that your cost share has been met for the month in question. The provider that provides the last service necessary to meet your share of cost will send the white copy to HHS and keep the Gold copy for his/her records.
2. For services that you received before this month, DO NOT USE THIS FORM.
3. For services received this month, either have your provider fill out this form or attach medical bills to this form.
4. At the top of the other side of this form in FIELD #1 is a box labeled "SHARE OF COST". The amount shown in this box is the amount you must pay your provider(s) or agree to pay toward your medical/dental bills before Medicaid will pay. Medical expenses for any family member shown on this form can be used to meet the share of cost. DO NOT SEND CASH OR CHECKS TO THE LOCAL OFFICE OF THE DEPARTMENT.
5. Take this form to any provider from whom you receive necessary medical/dental services (e.g., doctor, dentist, pharmacist, hospital, etc.) in the month specified. The provider will fill in the amount you have paid or have agreed to pay. YOU SHOULD NOT PAY OR AGREE TO PAY MORE THAN THE AMOUNT SHOWN IN THE "SHARE OF COST" BOX. YOU ARE RESPONSIBLE FOR THE ENTIRE AMOUNT SHOWN IN THE "CLIENT SHARE OF COST" COLUMN. Once the share of cost is met, allow the provider to mail the white copy of the form to the Department.
6. If all the provider boxes on this form have been used and you have not paid or obligated your share of cost, contact your case worker for more forms.
7. When you have met your "share of cost" it is your responsibility to let medical provider(s) know that you are Medicaid qualified. Use your copy of this completed form to show providers that you have met your share of cost and are Medicaid qualified for the month listed in FIELD #1. (NOTE: Medical claims will not be accepted until this form has been processed and case eligibility updated).
8. If you have any question about this form, call your case worker.