NOTICE OF APPROVAL OF SERVICE REQUEST

RE: MID:

Dear

in

makes approval and denial decisions for the CAPDA Waiver County for the Community Alternatives Program

(CAP/DA).

The above named lead agency took the action(s) specified below:

on the behalf of the Division of Medical Assistance (DMA) has made an approval decision for participation in the Community Alternative Program for Disabled Adults-Choice Option waiver, based on a prior approved level of care decision by N.C. Medicaid program. This authority is granted to the North Carolina Department of Health and Human Services by Title XIX of the Social Security Act, the North Carolina State Plan for Medical Assistance, and the N.C.G.S. §108A-54.

A prior approved FL-2 at a nursing facilty level of care and a comprehensive assessment have identified medical and functional needs which is reflective in an individualized POC.

	DMA 3504		
,	01/05/06	Si necesitas ayuda para leer y entender la carta, por favor contáctese	
	REV. 03/02/07	con el 1-800-662-7030. DIGA AL OPERADOR QUE LA	
	REV. 09/24/08	NOTIFICACION DMA 3504.	
	The above Spa	nish footer must be affixed to your agency's letterhead. Copy and paste the above footer to	
		oyour letterhead and remove this statement when completed.	
		Do not delete form numbe and date in left corner of this footer.	
	REV. 05/26/10		
	REV. 05/23/11		

Listed below are the services in the amount, frequency and duration that the above named beneficiary has been approved to receive.

NAME OF SERVICE	# OF UNITS APPROVED	TIME PERIOD (IF RELEVANT)

The service indicated below were DENIED, REDUCED, OR TERMINATED based on the care needs of the above named beneficiary.

The beneficiary and/or his/her /legal guardian were notified in writing of this action and their right to appeal.

NAME OF SERVICE	# OF UNITS APPROVED	DENIED, REDUCED, TERMINATED	TIME PERIOD (IF RELEVANT)

Also, please note the following:

- 1. See the specific clinical coverage policy and Medicaid's Basic Billing Guide for complete details regarding provision of and payment for services rendered. Clinical coverage policies and the Basic Medicaid Billing Guide can be found at http://www.ncdhhs.gov/dma/provider/library.htm.
- 2. Obtaining prior approval does **not** guarantee payment or ensure beneficiary eligibility on the date of service. A beneficiary must be eligible for Medicaid coverage on the date the procedure is performed or the service rendered, and the provider must be an enrolled Medicaid provider for that service and provider type on the day of service.
- 3. The service must be rendered as specified in this notice, including service approved, number of units approved, time period of approval, if relevant. See previous page regarding details of authorization.
- 4. Effective the date of this notice, this prior approval authorization is time limited to the first of the following to occur:
 - a. time limit specified by this prior approval **OR**
 - b. 365 days from date of this prior approval.
- 5. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits end on the day of the beneficiary's twenty-first birthday. Upon reaching 21, the beneficiary is no longer entitled to receive services that exceed policy limits or a non-covered state Medicaid Plan Service.
- 6. The provider has up to 365 days from the date the service is rendered to submit the claim for payment. See specific clinical coverage policy and the Basic Medicaid Billing Guide for complete details regarding provision of and payment for services rendered.

If you have questions concerning this notice of approval, please contact at . Thank you for serving the citizens of North Carolina by participating in the Medicaid program.

Sincerely,

CC: Beneficiary Service Provider Beneficiary Record