Dear <<<*collection agency representative*>>>:

I got information on my health coverage. Some or all of the bills listed on the letter you sent me from *provider* dated <<<>>> detailing the charges at issue were for Medicaid-eligible services.

Enclosed please find information from the Health Care Authority showing that, of the dates in question, I was on Medicaid from <<<*date*>>> through <<<*date*>>>. I informed the provider about my coverage. They knew I had Medicaid.

Even if you believe the provider's claim that I did not disclose my Medicaid status, it does not matter. It is the provider's responsibility to verify medical coverage. WAC 182-502-0160(2).

The provider has also argued that Medicaid may not have covered the services, and that I signed waiver forms authorizing the service. The waiver forms I signed do not comply with WAC 182-502-0160(5), which reads:

(a) The agreement must:

(i) Indicate the anticipated date the service will be provided, which must be no later than ninety calendar days from the date of the signed agreement;

(ii) List each of the services that will be furnished;

(iii) List treatment alternatives that may have been covered by the agency or agency-contracted MCO;

(iv) Specify the total amount the client must pay for the service;

(v) Specify what items or services are included in this amount (such as pre-operative care and postoperative care). See WAC 182-501-0070(3) for payment of ancillary services for a noncovered service;

(vi) Indicate that the client has been fully informed of all available medically appropriate treatment, including services that may be paid for by the agency or agency-contracted MCO, and that he or she chooses to get the specified service(s);

(vii) Specify that the client may request an exception to rule (ETR) in accordance with WAC 182-501-0160 when the agency or its designee denies a request for a noncovered service and that the client may choose not to do so;

(viii) Specify that the client may request an administrative hearing in accordance with chapter 182-526 WAC to appeal the agency's or its designee denial of a request for prior authorization of a covered service and that the client may choose not to do so;

(ix) Be completed only after the provider and the client have exhausted all applicable agency or agency-contracted MCO processes necessary to obtain authorization of the requested service, except that the client may choose not to request an ETR or an administrative hearing regarding agency or agency designee denials of authorization for requested service(s); and

(x) Specify which reason in subsection (b) below applies.

(b) The provider must select on the agreement form one of the following reasons (as applicable) why the client is agreeing to be billed for the service(s). The service(s) is:

(i) Not covered by the agency or the client's agency-contracted MCO and the ETR process as described in WAC 182-501-0160 has been exhausted and the service(s) is denied;

(ii) Not covered by the agency or the client's agency-contracted MCO and the client has been informed of his or her right to an ETR and has chosen not to pursue an ETR as described in WAC 182-501-0160;

(iii) Covered by the agency or the client's agency-contracted MCO, requires authorization, and the provider completes all the necessary requirements; however the agency or its designee denied the service as not medically necessary (this includes services denied as a limitation extension under WAC 182-501-0169); or

(iv) Covered by the agency or the client's agency-contracted MCO and does not require authorization, but the client has requested a specific type of treatment, supply, or equipment based on personal preference which the agency or MCO does not pay for and the specific type is not medically necessary for the client.

(c) For clients with limited English proficiency, the agreement must be the version translated in the client's primary language and interpreted if necessary. If the agreement is translated, the interpreter must also sign it.

(d) The provider must give the client a copy of the agreement and maintain the original and all documentation which supports compliance with this section in the client's file for six years from the date of service. The agreement must be made available to the agency or its designee for review upon request; and

(e) If the service is not provided within ninety calendar days of the signed agreement, a new agreement must be completed by the provider and signed by both the provider and the client.

This situation does not fall into one of WAC 182-502-0160(6)’s limited exceptions where a provider may bill a patient without executing the Agreement to Pay for Healthcare Services.

For the period I had Medicaid, representing $___.__ of the $___.__ billed, the provider violated the law by billing or trying to collect the charges from me. I have a refund coming from the provider for all improperly charged amounts you have collected from me.

Please cease all further collection attempts immediately. Thank you.

Sincerely,

<<<<*Your name*>>>