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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
COST SHARING MEDICAL EXPENSE RECORD – HIPP FOR KIDS PROGRAM

PERSONAL DATA

Name:_____ Phone Contact Number:_____

Street Address:_____City:_____State:_____Zip:_____

HIPP For Kids Case Number:_____ HIPP for Kids Case Name:_____

Expense Period:_____

I understand, agree and certify to the following:

- I am requesting reimbursement for the service provided below for the amount that has been paid by the employee.
- I have exhausted all the other sources of reimbursement, including those provided under Medicaid, my Employer's plan(s) and any other plan before seeking reimbursement under HIPP For Kids.
- I have not previously submitted a reimbursement request for the cost sharing indicated below.
- I understand reimbursement will be provided on a quarterly basis.
- I understand that I must submit a completed form(s) and an Explanation of Benefits (EOB) for each service provided and a receipt showing payment for the responsible amount.
- I understand that reimbursement can only be provided for services covered my qualified employer's sponsored coverage that is approved for HIPP For Kids and covered under the Medicaid State plan for the Medicaid enrolled child(ren) under age 19 and parent(s).
- I understand that there is no reimbursement for costs associated with services received from providers who do not participate in my employer sponsored health plan (out of network services).
- I have read and understand the information on the front and back of this form.

COST SHARING MEDICAL EXPENSE RECORD:

NAME OF MEDICAID CHILD UNDER 19 OR PARENT WHO RECEIVED THE SERVICE	RELATIONSHIP TO EMPLOYEE	NAME OF PROVIDER OF SERVICES*	TYPE OF SERVICE RECEIVED	SERVICE DATE**		AMOUNT THAT YOU PAID
				FROM: (MM/DD/YYYY)	TO: (MM/DD/YYYY)	
					TOTAL THIS PAGE	$
					GRAND TOTAL FOR MULTIPLE PAGES	$

Participant's Signature:_____ Date:_____

(Required to process reimbursement)

* Provider of Services means hospital, doctor, dentist, drugstore, medical supply store, etc.
** Service date refers to dates service was PROVIDED or available for pickup, not the date you paid or were charged for it.

MAIL TO: DMAS, HIPP For Kids Program, 600 E. Broad Street 12th Floor, Richmond, VA 23219

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IMPORTANT INFORMATION FOR REIMBURSEMENT

(TO AVOID DELAYS, PLEASE READ THESE INSTRUCTIONS CAREFULLY)

IMPORTANT REQUIREMENTS & INFORMATION (not following these requirements may cause your reimbursement payment to be rejected)

- Complete all lines in the Personal Data Section.
- Your HIPP For Kids Case # can be obtained from your approval letter.
- Submit copies of Explanation of Benefits (EOB) and documentation of payment in the same order as listed on the Cost Sharing Medical Expense Record.
- Employee/policy holder must sign and date the Cost Sharing Medical Expense Record.
- Attach additional sheet(s) for more items.
- Retain a copy of your Cost Sharing Medical Expense Record(s) and all payment documentation for your records.
- Cost sharing medical expenses are reimbursed quarterly as follows:

Medical Expense Period	Receipt Deadline	Reimbursement Month
January thru March	May 5th	June
April thru June	August 5th	September
July thru September	November 5th	December
October thru December	February 5th	March

DOCUMENTATION REQUIREMENTS:

Documentation must include the following:

- Name of person receiving services, this must be the parent or Medicaid enrolled child under the age of 19 covered under the qualified employer sponsored coverage approved for HIPP For Kids.
- Type of service(s) such as x-ray, office visit, prescription drug name, etc.
- Date service(s) were received (not necessarily same as date paid).
- Your cost for the service(s). Total amount that is your responsibility that you paid.
- An EOB showing the amount you are responsible to pay as well as documentation/receipt showing payment of the amount. Receipt can be a cancelled check, receipt from medical provider, bank account statement showing deduction, debit/credit card statement showing payment. Copies of the duplicate portions of checks is not acceptable documentation, it must be a check which that has been processed by your bank or financial institution.

QUESTIONS:

Visit the HIPP For Kids website at: http://www.dmas.virginia.gov/rcp-HIPP.htm

Contact the HIPP For Kids Program at (804) 225-4236 or (**800) 432-5924 (in Virginia only)**

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