Request for Offset for Prescription Drugs

_____

_____ Authorized Representative

_____ Address

_____ RE: _____

_____ Medicaid #:_____

Dear Sponsor:

You have requested information regarding offsetting income to use for non-covered medical prescriptions for a nursing home recipient. The Alabama Medicaid Agency allows nursing home recipients to retain funds (adjust the liability amount owed the nursing home) from their available income to pay for these costs. Necessary medical services that are authorized for offset must be medically necessary, must not be a Medicaid covered service for this recipient, must not be subject to payment by Medicare or any other third party health insurance (including Medicare premiums, deductibles and coinsurance), and must be incurred during a period which is no more than three months prior to the month of new application for Medicaid benefits. For approved requests, the offset will be based upon the lesser of the established Medicaid payment or the actual expense (invoice, etc.). No offset will be allowed until after the expense has been incurred and verified. **The completed Request for Offset form and supporting medical documentation must be received by the Medicaid Agency within 6 months of the expense being incurred or within 6 months from the date of the award notice to be considered.**

Procedure for Requesting Offset:

1. Provide the Request for Offset Form to the prescribing provider to request authorization for medically necessary prescriptions not covered under Part D. Preferably this form would be submitted prior to the service being provided in order to determine if Medicaid will authorize offset for the service. The request will be accepted up to six months after the medical expense is incurred or within 6 months from the date of the award notice, however, there is no guarantee Medicaid will authorize the offset.

2. Gather required documentation. All requests must contain documentation by the prescribing provider of the medical necessity of the service along with sufficient documentation of services and costs. Documentation may include peer reviewed literature as well as copies of the patient chart. **Medical necessity documentation must also include reason why a switch to a therapeutic alternative is not warranted**. **Copies of all insurance cards/proof of coverage and a copy of the appeal denial from the beneficiaryôs drug plan for the requested drug must be included.**

3. Submit the offset form and all supporting documentation to the following address:

Alabama Medicaid Agency
ATTN: _____
_____
_____
_____

You will be notified by mail of Medicaidôs decision.

Sincerely,

_____
Medicaid Representative
Phone # _____

Request for Offset Form for Prescription Drugs

The Alabama Medicaid Agency allows nursing home recipients to retain funds (we adjust the liability amount owed the nursing home) from their available income to pay for medically necessary prescription drugs not covered under Medicare Part D that cannot be substituted. **Itemized statements and documentation from the prescribing physician (such as peer reviewed literature, copies of the patient chart showing patientôs chart showing physician order/nurses notes, x-rays, lab reports, etc.), and a copy of the Medicare or other third party appeal denial for the requested drug must be submitted with this form in order for offset to be considered.**

Prescribing Provider Information:
Provider

Name _____

License # _____

Phone _____

Recipient Information:
Recipient Name _____

Medicaid #: _____

Authorized Representative_____

Brand/Generic Name	Date Dispensed	Quantity	Day Supply	Price
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Explain the medical justification. Documentation from the patient record (history and physical, tests, past or current medication/treatments, patientôs response to treatment, etc.) illustrates and supports the physicianôs request for the drug specified.

_____

_____

The patient referenced above has incurred or plans to incur a medical expense that is not covered by Medicare, Medicaid or other third party health insurance. I certify that the requested service is medically indicated and necessary for the treatment of this patient.

_____ _____

Signature of Prescribing Physician Date

Mail confidential to:

Alabama Medicaid Agency
ATTN: _____
_____
_____
_____

Form 243a