Request for Non-Covered Services Pre/Post-Eligibility Deductions

To: Office of Eligibility Services
Department of Health & Mental Hygiene
201 West Preston Street, Room SS-10
Baltimore, Maryland 21201-2399

From: __________________________ Local Department of Social Services

______________________________

D.O. #________________________
Date Request Sent________________

Please complete the following information: □ New Request □ Resubmission
Case Manager ____________________ Contact Number ____________________
Case Name ____________________ Client ID Number ____________________
Application Date ______________ Current Certification Period ______________

Penalty Period (if applicable) From ________ To ________

Retro Period ____________________

Has an eligibility determination been made for the retro period? □ Yes □ No
(A determination must be made for the retro months requested before submitting this form*)

Retro Eligibility Determination

1st Month _______________ □ Approved □ Denied □
2nd Month _______________ □ Approved □ Denied □
3rd Month _______________ □ Approved □ Denied □

Attach a copy of denial notices for all current and retro months. *This does not apply to Waiver cases.

Type of Expense
(Place a check mark next to the appropriate type.)

□ Dental Bill □ Hearing Aid Bill
□ Vision Bill □ Podiatry Bill
□ Pharmacy Bill □ Nursing Home Bill
□ Other (Please Specify):

______________________________

OES 001 (LTC) Revised 08/12  All other versions are obsolete. All information MUST be completed