

COUNTY INDIGENT HEALTH CARE PROGRAM CLAIM PROCESSING NOTIFICATION

To: _____	From: _____
_____	_____
_____	_____

1st Date Original Claim is Received

Date Form 110 is Issued

Patient's Name

CIHCP Case Record Number

The attached claim cannot be processed for payment due to the following checked item(s):

1. This claim was not received within the CIHCP 95-day billing timeframe.
2. This patient was not eligible for CIHCP on the date(s) of service listed on the attached claim.
3. This patient has reached the CIHCP \$30,000 or 30-day maximum county liability.
4. Appropriate CIHCP provider notification requirements were not followed.*
5. This claim is not for a CIHCP basic or department-established optional service.
6. This claim must be submitted on the following claim form: CMS-1500 UB-04.
7. The services on this claim are not itemized.
8. The patient is now Medicaid eligible. ID# _____ Add Date: _____
9. The patient has applied for SSI/Medicaid benefits; claim will be held until a decision is received.
10. The attached Form 113 must be completed, signed, and dated.
11. Other: _____

* Refer to Chapter 61, Health and Safety Code, §§ 61.031 and 61.032.

<input type="checkbox"/> This claim may not be resubmitted. <input type="checkbox"/> If the above-checked items are corrected, this claim may be resubmitted and will be processed for payment if it is received in this office by: _____ <div style="text-align: right; margin-right: 50px;">(Deadline Date)</div> <p style="text-align: center;">If the corrected claim is not received by this deadline date, we will assume that your office is not interested in pursuing payment.</p>
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If you have any questions regarding this claim, please contact our office at _____.

Sincerely,

Signature