**Reed & Associates, CPAs – CMS Retroactive Processing Contractor (RPC)**

**RPC Documentation Worksheet**

***This document is required for all retroactive Low Income Subsidy (LIS) status change transactions.***

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| **Date:** |       | **Contract Number:** |       | **Plan Type:** |       |
| **Beneficiary Name:** |       |
| **Beneficiary ID (MBI):** |       | **Effective Date:** |       |
| **Dual Eligible Status** **(Medicaid Status Level):** | [ ]  Partial (also *SSI-only recipients &* *Full Duals with income > 100% FPL)*[ ]  Full |
| **Institutional or Home and Community-Based Services (HCBS) Status Level:** | [ ]  No [ ]  Yes [ ]  HCBS [ ]  Unknown  |
| **Reason for Request** *(Please be as detailed as possible)***:**       |
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| **General Retroactive LIS Documentation Guidelines****(Please submit only copies of the documentation listed below)** |
| Documentation Required for High and Low Co-Payment Requests |
| *See the “Documentation Required” section of the LIS Deeming Update SOP for additional documentation requirements* | **[ ]**  A copy of the member’s Medicaid card which includes the member’s name, eligibility date, and status level | **[ ]** SSA publication HI 03094.605 confirming that the beneficiary is “…automatically eligible for extra help…” |
| **[ ]**  A print out from the State electronic enrollment file showing Medicaid status | **[ ]**  A screen print from the State’s Medicaid systems showing Medicaid status | **[ ]**  A copy of a state document that confirms active Medicaid status |
| **[ ]** Supplemental Security Income (SSI) Notice of Award with an effective date | **[ ]**  Other documentation provided by the State showing Medicaid status | **[ ]**  A screenshot of an RO completed beneficiary assistance request CTM |
| Documentation Required for Zero Co-Payment Requests |
| **[ ]**  A remittance from the facility confirming stay and/or Medicaid payment for that individual for a month after June of the previous calendar year.  | **[ ]**  A State Medicaid document showing the individual’s institutional status for a month after June of the previous calendar year.  | **[ ]**  A screen print from the State’s Medicaid systems showing the individual’s institutional status for a month after June of the previous calendar year.  |
| **[ ]**  A State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary’s name and HCBS eligibility date | **[ ]**  A State-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary’s name and the dates of HCBS | **[ ]**  A State-issued prior authorization approval letter for HCBS that includes the beneficiary’s name and effective date |
| **[ ]**  A State-approved HCBS Service Plan that includes the beneficiary’s name and effective date | **[ ]**  Other documentation provided by the State showing HCBS eligibility status | **[ ]**  A screenshot of an RO completed beneficiary assistance request CTM |
| **[ ]**  A report of contact as evidence of a beneficiary's status as a full benefit dual eligible individual, institutionalized individual, and/or HCBS recipient; including: the date a verification call was made to the State Medicaid Agency and the name, title, and telephone number of the state staff person who verified the Medicaid status |

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