



COMMONWEALTH of VIRGINIA  
Department of Medical Assistance Services  
Medicaid Claims Request

CYNTHIA JONES  
ACTING DIRECTOR

600 EAST BROAD STREET  
RICHMOND, VA. 23219  
PHONE: (804) 786-7933  
FAX: (804)225-4512

Date: \_\_\_\_\_

Agency: \_\_\_\_\_

Worker's Name: \_\_\_\_\_

Phone No: \_\_\_\_\_

Recipient Audit Unit Supervisor  
Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

Dear Supervisor:

I am conducting an investigation of the person(s) listed below for the time period indicated. Please forward proof of claims paid by Medicaid during the investigative period.

Custodian Certificate/Claims needed? Y/N  
Written referral following? Y/N  
Expected Date to the CA: \_\_\_\_\_  
Expected Court Date: \_\_\_\_\_

I will keep you informed of additional progress and of the outcome of this investigation.

Case Name: \_\_\_\_\_ Base ID#: \_\_\_\_\_

(a) \_\_\_\_\_ Recipient ID#: \_\_\_\_\_

Period of suspected fraud/overpayment: \_\_\_\_\_

(b) \_\_\_\_\_ Recipient ID#: \_\_\_\_\_

Period of suspected fraud/overpayment: \_\_\_\_\_

(c) \_\_\_\_\_ Recipient ID#: \_\_\_\_\_

Period of suspected fraud/overpayment: \_\_\_\_\_

(d) \_\_\_\_\_ Recipient ID#: \_\_\_\_\_

Period of suspected fraud/overpayment: \_\_\_\_\_

Sincerely,

## **CLAIMS REQUEST FORM INSTRUCTIONS**

**FORM NUMBER - DMAS 750R**

### **PURPOSE:**

This form serves as a multi-purpose form. It can be used to receive certified claims from DMAS reporting the total expended amount of Medicaid services for the period of time in question. These claims are used in court testimony, as evidence against the defendant. Restitution is ordered based on the amount of claims in the form of a custodian certificate that is submitted by the supervisor of the Recipient Audit Unit. This information is notarized, and is attesting to the fact that the information is accurate and that the supervisor serves as the keeper of the records for DMAS. The claims inquiry will also assist the agency in determining whether to include the Medicaid claims with a joint criminal referral. If the agency determines that a joint criminal referral will not be made, the worker/investigator must send the Recipient Fraud/Non-Fraud Referral to DMAS. DMAS determine if non-fraud recovery is appropriate and request restitution.

**NOTE:** Providers have up to one year to bill for services, therefore the amount of claims may not be accurate or complete at the time of prosecution or inquiry. It is suggested that the Commonwealth's Attorney be advised of this information, should additional claims develop at a later time and additional restitution be requested by DMAS.

**USE OF FORM** – Request of recipient claims for any investigation conducted by the local agency as it relates to person(s) receiving a money grant under the Temporary Assistance for Needy Families and Food Stamp program(s). Also, request for an estimate of claims when determining whether or not the Medicaid-Only case will be included with a joint criminal referral.

**NUMBER AND DISTRIBUTION OF COPIES** – **Prepare original; make a copy for the agency record before sending to the Recipient Audit Unit at DMAS.**

**INSTRUCTIONS FOR PREPARATION OF FORM** – The form should contain the case name, the base case ID number, each recipient ID number and the period of suspected fraud/overpayment for each recipient. Each recipient should be listed separately as shown on the form by the letters (a) through (d). Should there be additional recipients on the same base case ID, a second page should be attached.

**The requestor must complete the four questions in the lower left corner of the form in order for DMAS to determine the priority of the request. Failure to complete the questions will result in a delay of claims processing.**

The recipient(s) should be referred to DMAS if there was a period of time when the recipient was not eligible to receive benefits and the agency is unsure of how to handle the case.