

Cabinet for Health Services
Department for Medicaid Services
**NOTICE OF FRAUD AND/OR ABUSE
COMMITTED AGAINST THE
MEDICAID PROGRAM**

Medicaid Recipient Name _____ Medicaid Number _____

Address _____

Date: _____

Dear _____:

After checking your records, it was found that you received \$_____ in medical benefits covered by the Medicaid Program to which you were not entitled. This happened during the period from _____ to _____.

The Department for Medicaid Services believes that you were not entitled to these covered benefits because: _____

YOU MAY BE REQUIRED TO REPAY THE MEDICAID PROGRAM FOR COVERED BENEFITS RECEIVED INAPPROPRIATELY. FAILURE TO REPAY THE PROGRAM MAY RESULT IN A DISQUALIFICATION PERIOD NOT TO EXCEED ONE YEAR.

Pursuant to KRS 205.8451, fraud against the Medicaid program means "an intentional deception or representation made by a recipient with the knowledge that the deception could result in some unauthorized benefit to the recipient or provider or to some other person. It includes any act that constitutes fraud under applicable federal or state law."

Pursuant to KRS 205.8451, recipient abuse against the Medicaid program means "practices that result in unnecessary cost to the Medicaid program or the obtaining of goods, equipment, medicines, or covered benefits that are not medically necessary, or that are excessive, or constitute flagrant overuse or misuse of Medicaid program benefits for which the recipient is covered."

You have thirty (30) days from the date of this letter to respond to the Department for Medicaid Services. Failure to respond in a timely manner may result in the loss of your Medicaid eligibility.

Please respond to the Department for Medicaid Services by completing the section below and returning the form in the enclosed envelope:

- I admit that I committed fraud and/or abuse against the Medicaid program and I agree to repay the amount of money listed above.
- I request a fair hearing in accordance with KAR 907 1:563.
- I admit that I committed fraud and/or abuse and understand that I will be disqualified if I don't pay in full.

Failure to make a lump sum payment within two months from the date of the hearing decision will result in disqualification from the Kentucky Medicaid Program for a period not to exceed one year. If during the one year period of disqualification the amount owed to the Department for Medicaid Services is repaid in full, you may reapply for Medicaid benefits at your local Department for Community Based Services office. Also, at the completion of the twelve month disqualification you may reapply for Medicaid at your local Department for Community Based Services office.

Please see the back of this form for a list of options and an explanation of your hearing rights.

YOU HAVE THE RIGHT to a hearing in accordance with 907 KAR 1:563 to determine if you committed fraud and or abuse against the Medicaid program. At that hearing the agency has the burden of proving you committed fraud and or abuse against the Medicaid program.

YOU ALSO HAVE THESE RIGHTS:

1. You have the right to request a hearing within thirty (30) days of the date of this notice. Your written request should be mailed to the Department for Medicaid Services, Program Integrity and Utilization Review Branch, 6E-A, 275 East Main St., Frankfort, KY 40621.
2. You may represent yourself at the hearing or be represented by anyone you choose, including a friend, relative, community worker, or lawyer.
3. You or your representative may look at your case record BEFORE and during the hearing. The local DCBS office shall give you one FREE copy of parts of your case record pertaining to the issue in question if you ask in writing. The Department for Medicaid Services shall give you one free copy of any documents they or the Office of the Inspector General use in your hearing in accordance with confidentiality procedures.
4. The Department for Medicaid Services shall not use any proof at the hearing that you were not given a chance to look at before the hearing.
5. You may say anything at the hearing that you think will help your case and may refuse to answer questions during the hearing.
6. You may bring proof to the hearing that you feel helps your case.
7. You may bring witnesses to the hearing, and you may ask your witnesses and the Department for Medicaid Services any relevant questions that you want to ask.
8. You may explain why you think any statements made or proof given by the Department for Medicaid Services is wrong.
9. If you fail to attend the hearing, it may be held without you, based on information given by the Department for Medicaid Services. You have 10 days from the date of the hearing to explain why you did not attend. If the Hearing Officer decides that you had a good reason for not attending, a new hearing may be held.
10. You may continue to participate in the Medicaid Program while a hearing is pending, but you will have to repay the agency for any covered benefits you inappropriately receive during the hearing period if the hearing officer upholds the agency's decision.
11. If you lose the hearing, you shall be told of your right to appeal.

This hearing shall not prevent the State or Federal government from prosecuting you for fraud and or abuse against the Medicaid Program in a civil or criminal court action. You may be able to get LEGAL AID from you local legal aid office at () _____.

Signature of Medicaid Recipient/Applicant

Date

Signature of Interested Party

Date