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

Date Received by DHMH

From: ________________________________Local Department of Social Services

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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
Months being requested:

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☐ Other (Please Specify):

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