



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 FAMILY SUPPORT DIVISION
APPROVAL NOTICE

FROM	CASEWORKER NAME		TELEPHONE NUMBER	DATE
	COUNTY OFFICE ADDRESS (STREET)			
	CITY, STATE, ZIP CODE			
TO	NAME		RE	CASE NAME
	ADDRESS (STREET)			CASE NUMBER
	CITY	STATE	ZIP CODE	NOTE: Case number(s) listed above is not a Medicaid number. See back side for Medicaid number.

This is to advise you the following persons are approved for the stated type of assistance:

You have been approved as a Qualified Medicare Beneficiary effective _____.
 You may expect payment of your Medicare premiums to begin within 60 to 90 days from the date of this letter.

Persons listed below were determined not eligible for the stated type of assistance:

because

Based on information you helped provide, our investigation of your income and expenses shows that:
 your monthly check will be \$ _____. This is based on income before taxes of \$ _____ per _____.

other: _____

You have the right to appeal decisions made involving your application. You can request a hearing within 90 days from the date of this letter by calling _____. If you request a hearing you may present your information yourself or you may be represented by your own attorney or by other persons who know your situation. You have the right to present witnesses in your behalf and to question witnesses who appear at the request of the Family Support Division. For the possibility of free legal services, call _____.

If your situation changes, you must report these changes at once to the Family Support Division office. It is important you notify us if you have changes in your household, such as income, family size, or insurance. Also, please notify us if you move so that you receive any notification regarding your Medicaid and/or checks. If you have questions about changes to report, call the office at the phone number listed above. If your situation changes it is your responsibility under the law to report these changes at once to the local county office. The law provides penalties for any persons who receive benefits to which they are not entitled through misrepresenting the facts or not reporting full information about their situation.

ENCLOSURE: INFORMATION LEAFLET NO. _____	CASEWORKER SIGNATURE
IMPORTANT: THE BACK OF THIS FORM MAY CONTAIN VERIFICATION OF YOUR MEDICAL COVERAGE.	

THIS NOTICE WILL ALSO SERVE TO VERIFY ELIGIBILITY FOR MEDICAL SERVICES FOR THE PERSONS LISTED BELOW UNTIL THEIR REGULAR MEDICAID CARD IS RECEIVED.

ELIGIBLE FOR MEDICAID BENEFITS

QMB	NAME (LAST)	NAME (FIRST)	NAME (MIDDLE)	MEDICAID NO.	PERIOD OF COVERAGE *	
					FROM	TO

* Period of coverage includes the Prior Quarter Yes No You are not eligible for prior quarter/month coverage because

TO THE VENDOR:

QUALIFIED MEDICARE BENEFICIARIES: Persons with a "Y" indicator in the QMB field are eligible for benefits in addition to regular Medicaid, which includes Medicare covered services. Total Medicaid payment for Medicare covered services will consist of co-insurance and deductible amounts, as determined by the Medicare program.

MEDICAID LOCK-IN PROGRAM

THIRD PARTY LIABILITY

<input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PHARMACY <input type="checkbox"/> OPTOMETRIST <input type="checkbox"/> DENTIST <input type="checkbox"/> PODIATRY <input type="checkbox"/> O.P. - E.R. FACILITY	NAME:	
	INS. CO.:	INS. CODE:
	NAME:	
	INS. CO.:	INS. CODE:
NAME	NAME:	
ADDRESS	INS. CO.:	INS. CODE:
NAME	NAME:	
ADDRESS	INS. CO.:	INS. CODE: