TEXAS Health and Human Services Commission

Individual Name	
Individual No.	Date
Case Manager	
Office Address and Telephone No.	

Notification of Eligibility

Regular Medicaid Benefits

You are eligible for Medicaid. This includes help with payment for doctor's services, prescribed medicines, hospital services, and nursing facility care. You will receive a form each month which shows your Medicaid number. If you have any questions, contact this office.

☐ **Your Medicaid benefits begin** _____ , and end _____

☐ **Your Medicaid benefits begin** _____

☐ **Please ask each provider to write "RETROACTIVE MEDICAID" on the claim form. You may show this letter to the provider.**

☐ **For Nursing Home/ICF-IID Medicaid**
Based on your income, you must pay:

From (month/day/year)	Through (month/day/year)	Amount you owe the facility per month	From (month/day/year)	Through (month/day/year)	Amount you owe the facility per month

* If you were in the facility for part of a month or Medicare covered you for part of a month, the amount you pay will be prorated.

☐ **Medicaid Qualified Medicare Beneficiaries**

You are eligible to receive Medicaid Qualified Medicare Beneficiary (MQMB) benefits. As an MQMB, the Health and Human Services Commission (HHSC) will pay* your Medicare premiums (both Parts A and B), deductible, and co-insurance fees for Medicare-covered services.

Your benefits begin _____ Because your enrollment in Part A Medicare

is not effective until _____ , your eligibility for MQMB is delayed until that date.

☐ **Medicaid Specified Low-Income Medicare Beneficiaries**

You are eligible to receive Medicaid Specified Low-Income Medicare Beneficiaries (M-SLMB) benefits. As an M-SLMB, the Health and Human Services Commission (HHSC) will pay your Medicare Part B premiums.

Your benefits begin _____

*** Your Social Security or Railroad Retirement check will increase by the amount of the premium. It may take up to 120 days for this increase to occur.**

(continued on page 2)

Comments:

Each month you will receive an identification card which you should show to your medical providers. You are responsible for reporting any change in your situation to me within 10 days of learning about that change.

Request to Appeal Case Manager's Decision

You may request a hearing to appeal this decision. Your right to appeal this decision is lost 90 days from the date of this letter.

If you request a hearing, you may be represented by an authorized representative, a relative, a friend or legal counsel. Free legal help from outside the department is available in many communities; call your local department office for information. If either you, your representative or a hearing officer asks, I will be present at the hearing.

Whether or not you want a hearing, you may request an informal conference to discuss this decision. If you want a conference, contact me and I will make the arrangements.

If you do not want a hearing, do not return this letter. If you do not return your request for a hearing within 90 days from the date of this letter, you will lose your right to a hearing.

Complete this section ONLY if you are NOT satisfied with this decision and wish to appeal:

☐ **Request for Appeal**

I file this as my appeal and want a hearing before a department hearing officer.

Signature – Individual

Date

Individual Name	Area Code and Telephone No.

SEND THIS REQUEST FOR AN APPEAL TO THE CASE MANAGER AT THE FOLLOWING ADDRESS:

Case Manager	Mail Code
Office Address and Telephone No.	

Discrimination Complaints

If you believe you have been discriminated against because of race, color, national origin, age, sex, disability or religion, you may file a complaint by contacting:

HHSC Civil Rights Office, 701 W. 51st St., Suite 104, MC W-206, Austin, TX 78751

Voice: 1-888-388-6332, TTY: 1-877-432-7232, Fax: 1-512-438-5885

You can also file a complaint by contacting the U.S. Department of Health and Human Services:
Office for Civil Rights - Region VI, 1301 Young St., Room 1169, Dallas, TX 75202