FLORIDA MEDICAID DIRECT REIMBURSEMENT
RECIPIENT INFORMATION REQUEST

Section I - Information Request (to be completed by the Agency for Health Care Administration)

Name: _____ Date: _____

Address: _____

_____

_____

Phone: ( ) _____

Medicaid Identification Number: _____

We received your request to refund you for medical goods or service(s) you paid for that may be Florida Medicaid covered services.

To help with your request, please send us the following:

☐ Proof from the Department of Children and Families (DCF) stating your Florida Medicaid application was denied, or benefits were closed, in error. Provide the DCF Florida Medicaid approval notice correcting the error.

☐ Copy of the bill(s) that describes the medical goods or services you received.

☐ Copy of the receipt(s) showing you, or a person legally responsible for your bills, paid for the medical goods or service(s).

☐ Other _____.

Section II - Recipient Confirmation (to be signed and dated by the recipient or person legally responsible for the recipient's bills)

I confirm the bill(s) were not paid, or could not have been paid, by any other medical insurance or settlement from a legal claim.

_____ _____

Florida Medicaid Recipient's Signature (or person legally responsible for the recipient's bills) Date

You have 12 months from the date of your notice of eligibility to email this information to direct_reimbursement@ahca.myflorida.com. The Agency for Health Care Administration will decide if you are eligible for a refund and mail you a check, if so. If you have any questions, call the Florida Medicaid Helpline at 1-877-254-1055. For those that do not have internet access, the form may be returned to the following address:

Agency for Health Care Administration
2727 Mahan Drive
MS# 58
Tallahassee, FL 32308
ATTN: Direct Reimbursement

AHCA Form 5240-0002, June 2016, incorporated by reference in Rule 59G-5.110, F.A.C.