DMAS LTSS SCREENING CHANGE TO MEMBER INFORMATION REQUEST FORM

Member enrollment change requests are made when there is an **auto-fill error** in eMLS of one of the following key demographic items: **NAME, SSN, MEDICAID ID, DOB, GENDER or RACE**. Or when the screener makes an error in one of the fields (**NAME, SSN, MEDICAID ID, DOB, GENDER or RACE)** and processed the screening through the system and the screening is now in an "ACCEPTED" status.

For all persons one (1) year old and above, this form MUST be submitted by the LTSS Screener to: enrollment@dmas.virginia.gov

For all persons under one (1) year old, this form MUST be submitted by the LTSS Screener to: Newborn@dmas.virginia.gov

Allow at least 14 days for all corrections.

Changes to the Medicaid record must be researched and confirmed to be appropriate. This process can take up to two weeks with an additional 48 hours to be reflected in the eMLS system once the change is made.

PLEASE DO NOT send multiple change requests for the same person or repeatedly email the enrollment office or screening assistance. Each time you submit an email for the same correction, the time it takes to resolve the issue "resets" from the beginning.

The Enrollment office can only address changes in the key demographic information. They are not able to respond to questions about MES, MMIS, CRMS, eMLS or screening policies and procedures. Do NOT send any other type of question to DMAS Enrollment.

It is essential you fully and accurately complete this form, as applicable, for all Medicaid record change requests.

Date of Submission of this Form to Enrollment: _____

LTSS SCREENER INFORMATION:

Name: **Contact information (phone and email):**

Full Name of Agency, Hospital, or Nursing Facility (please do not use initials):

REQUIRED INFORMATION FOR THE INDIVIDUAL:

Correct Name _____ **Correct DOB** _____

Correct SSN _____ **Correct Medicaid ID** _____

Screening Number _____ **Date of Screening** _____

Please Check One: Auto-Fill is Incorrect _____ Error Made During LTSS Screening _____

○ Incorrect Name	○ Incorrect Date of Birth	○ Incorrect Gender
○ Incorrect Social Security Number	○ Incorrect Date of Death	○ Race:

***How have you <u>verified</u> the correct information** (ex. social security card, driver's license, etc.)? This area MUST be completed.
*Please note that ALL name changes **MUST** match with the individual's Social Security card. No other source can be used for name changes. If the SS card is wrong the individual MUST contact the SS Administration before any Medicaid record can be corrected.*

For items needing correction: (Please list the wrong information auto-filled and the correction.)

Name of Individual	Wrong:	Correct:
Date of Birth	Wrong:	Correct:
Gender	Wrong:	Correct:
Race:	Wrong:	Correct:
Social Security Number:	Wrong:	Correct:
Medicaid Number:	Wrong:	Correct:

Return this Form as an Attachment to DMAS Enrollment
One (1) year old and above, enrollment@dmas.virginia.gov
Under one (1) year old, Newborn@dmas.virginia.gov