DMAS LTSS SCREENING CHANGE TO MEMBER INFORMATION REQUEST FORM

It is essential that all Medicaid records for an individual match. When the records match, the LTSS Screening links to the individual's appropriate Medicaid record in the Medicaid System allowing the existence of an approved LTSS screening to be confirmed for enrollment. If the demographics do not match, the records may not link correctly, and the individual seeking LTSS could be denied services.

Member enrollment change requests are made when there is an error in one of the following key demographic fields in eMLS:
NAME, SSN, MEDICAID ID, DOB, GENDER, or a DOD error message.

These errors occur either by auto-fill in the demographic fields while starting a Screening <u>OR</u> when the Screener makes an error manually and processes the Screening (Accepted Status) with the incorrect information.

To resolve these problems, this form must be completed and submitted to:

PatientPay@dmas.virginia.gov

Please label email with the following <u>subject line</u>:

LTSS Screening Member Information Change Request

Allow at least 14 business days for all corrections.
Changes to the Medicaid record must be researched and confirmed to be appropriate. PLEASE do NOT send multiple change requests for the same person or repeatedly email the enrollment office or screening assistance.

Once DMAS Enrollment has researched and made changes to the Medicaid record, you will be notified. Once notified you must wait an additional 48 hours for these changes to be reflected in the eMLS system. After 48 hours you must return to eMLS, CANCEL the newly started screenings that auto filled or VOID/DELETE for processed screenings and then re-enter all the screening information and resubmit. If applicable, use all the original screening dates including original signature dates.

The Enrollment office can <u>only</u> address and make changes to the <u>key demographic information</u>. Please DO NOT send any other type of question to DMAS Enrollment. Other questions should go to ScreeningAssistance@dmas.virginia.gov.

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

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Submission Date of this Form to Enrollment: _____

LTSS SCREENER INFORMATION*: Please print or type.*

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

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

LTSS Screening Number: _____   *Date of Screening:* _____

REQUIRED INDIVIDUAL INFORMATION:

Correct Name   _____   **Correct DOB** _____

Correct SSN   _____   **Correct Medicaid ID** _____

Please check all that apply: _____ Auto fill is Incorrect   _____ Error Made by Screener

o Incorrect Name	o Incorrect Date of Birth	o Incorrect Gender
o Incorrect Social Security Number	o Incorrect Date of Death	

*How have you <u>verified</u> the correct information, please explain (ex. Used social security card, driver's license, etc.)?   This area MUST be completed.

*Please note that <u>ALL name changes</u> **MUST** match with the individual's Social Security card. If the SS card is wrong the individual MUST contact the SS Administration before any Medicaid record can be corrected. It is not required to send a copy of the individual's social security card with this form, but it can expedite the process if you do so.*

For items needing correction: Please list the wrong information entered or auto filled and the correction needed.

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

Comments: _____

Return this Form as an Attachment to DMAS Enrollment at **PatientPay@dmas.virginia.gov**