CHAPTER 49

ADMINISTRATION MANUAL

Authority

N.J.S.A. 30:4D–1 et seq., specifically 6, 7 and 12; 30:6E-1 et seq.; 52:14D-1 et seq., and 42 C.F.R. 412.30.

Source and Effective Date

R.2003 d.81, effective January 22, 2003.
See: 34 N.J.R. 2647(a), 35 N.J.R. 1116(a).

Chapter Expiration Date

Chapter 49, Administration Manual, expires on January 22, 2008.

Chapter Historical Note

Chapter 49, Administration, was adopted and became effective prior to September 1, 1969. Subchapters 1 through 6 were amended by R.1977 d.213, effective July 1, 1977. See: 9 N.J.R. 123(b), 9 N.J.R. 342(c).

Pursuant to Executive Order No. 66(1978), Chapter 49, Administration, was readopted as R.1990 d.390. See: 22 N.J.R. 1512(a), 22 N.J.R. 2313(a).

Chapter 49, Administration, was repealed and a new Chapter 49, Administration, was adopted by R.1992 d.317, effective August 17, 1992. See: 24 N.J.R. 1728(b), 24 N.J.R. 2837(a). Subchapter 19, Prepaid Health Care Services: Medicaid Eligibles, was repealed by R.1995 d.337, effective June 19, 1995. See: 27 N.J.R. 853(a); 27 N.J.R. 2446(b).

Pursuant to Executive Order No. 66(1978), Chapter 49, Administration, was readopted as R.1997 d.354, effective August 8, 1997. As a part of R.1997 d.354, effective September 2, 1997, Chapter 49, Administration, was renamed Chapter 49, Administration Manual; Subchapter 2, New Jersey Medicaid Recipients, was renamed Subchapter 2, New Jersey Medicaid Beneficiaries; Subchapter 9, Provider and Recipient's Rights and Responsibilities; Administrative Process, was renamed Subchapter 9, Provider and Beneficiary's Rights and Responsibilities; Administrative Process; Subchapter 17, Home and Community–Based Services Waivers, was recodified as N.J.A.C. 10:49–22, Home and Community Based Services Waiver Programs; Subchapter 18, Home Care Expansion Program, was recodified as N.J.A.C. 8:81–2, and Subchapter 18, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), was adopted as new rules; Subchapter 19, HealthStart, was adopted as new rules; Subchapter 21, Pharmaceutical Assistance to the Aged and Disabled (PAAD), was recodified as N.J.A.C. 8:81–3, and Subchapter 21, The Medicaid Managed Care Program—NJ Care, was adopted as new rules; Subchapter 22, Lifeline Programs, was recodified as N.J.A.C. 8:81–4, and Subchapter 22, Home and Community–Based Services Waiver Programs, was adopted as new rules; and Subchapter 23, Hearing Aid Assistance to the Aged and Disabled, was recodified as N.J.A.C. 8:81–5, and a new Subchapter 23, Lifeline Programs, was adopted as new rules. See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Subchapter 24, Work First New Jersey/General Assistance Claims Processing, was adopted by R.2000 d.309, effective August 7, 2000. See: 32 N.J.R. 1342(a), 32 N.J.R. 2900(a).

Chapter 49, Administration Manual, was readopted as R.2003 d.81, effective January 22, 2003. See: Source and Effective Date. See, also, section annotations. Subchapter 20, The Garden State Health Plan (GSHP), was reserved by R.2003 d.82, effective February 18, 2003. See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

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SUBCHAPTER 1. GENERAL PROVISIONS

10:49–1.1 Scope and purpose

(a) The Division of Medical Assistance and Health Services, under the Department of Human Services, is designated in accordance with 42 C.F.R. 412.30, as the single State agency for the administration of the New Jersey Medicaid program. Under the authority of N.J.S.A. 30:4D–1 et seq., as amended and supplemented, N.J.S.A. 30:4D–5, and pursuant to N.J.S.A. 30:4D–4, 30:4I–1 et seq. and 30:4J–1 et seq., the Division of Medical Assistance and Health Services is authorized to administer the Medicaid program as well as other special programs. This chapter provides general and specific information about the regular Medicaid program; special Medicaid services or programs (such as HealthStart, Prepaid Health Plans, and Waivered programs); the NJ FamilyCare programs and other special (State) funded Programs.

(b) Governor Whitman's Reorganization Plan No. 001–1996 gives the Department of Health and Senior Services (DHSS) legal authority to administer several components of the Medicaid program. These components include nursing facility services, medical day care services, PreAdmission Screening (PAS) and PreAdmission Screening and Annual Resident Review (PASARR), the Community Care program for the Elderly and Disabled (CCPED) waiver, the Assisted Living/Alternate Family Care (AL/AFC) waiver, and peer grouping. Rules for these Medicaid program components are promulgated by DHSS. Accordingly, providers must contact DHSS regarding requirements for these services.

(c) Pursuant to N.J.S.A. 30:4D–1 et seq., as amended and supplemented, the Division of Medical Assistance and Health Services, under the Department of Human Services, is designated as the State agency responsible for the administration of the NJ FamilyCare program.

(d) Unless otherwise specified, or clearly indicated otherwise in the context of the rule, the rules of the New Jersey Medicaid program and the rules of the Division of Medical Assistance and Health Services are equally applicable to the NJ FamilyCare program.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Substantially amended section.
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (a), inserted a reference to the NJ KidCare program in the second sentence; and added (c) and (d).
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
Amended N.J.S.A. reference in (a) and (c).

10:49–1.2 Organization

(a) Regarding the organization of the Division of Medical Assistance and Health Services, the Department of Human Services is the single State Agency for receipt of Federal funds under Title XIX (Medicaid) and Title XXI of the Social Security Act. The Division of Medical Assistance and Health Services, Department of Human Services, administers the New Jersey Medicaid and the NJ FamilyCare program through its Central Office and through Medical Assistance Customer Centers (MACCs) located throughout the State of New Jersey. A listing of the MACCs is provided in the chapter Appendix. The Division may also designate from time to time agencies which will assist in the administration of the NJ FamilyCare program.

1. The two programs are jointly financed by the Federal and State governments and administered by the State. The New Jersey Medicaid program is conducted according to the Medicaid State Plan approved by the Secretary, United States Department of Health and Human Services, through the Centers for Medicare & Medicaid Services (CMS). The NJ FamilyCare program is conducted according to the Title XIX and Title XXI State Plans approved by CMS.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Section name amended; former (a) recodified as N.J.A.C. 10:49–1.3; recodified former (b) as (a); in (b)1, added ", through the Health Care

Financing Administration (HCFA)"; and deleted (c), relating to Medicaid Program services and eligibility.
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (a), inserted a reference to Title XXI of the Social Security Act in the first sentence, inserted a reference to the NJ KidCare program in the second sentence and added a fourth sentence in the introductory paragraph, and substituted "two programs are" for "program is" in the first sentence and added a third sentence in 1.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

10:49–1.3 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Adult mental health rehabilitation services provided in/by community residence programs" means community residential mental health services provided in/by any community residential program licensed by, and under contract with, the Division of Mental Health Services (DMHS), which provides services in accordance with N.J.A.C. 10:37A. These services include assessment and evaluation; individual service coordination; training in daily living skills; residential counseling; life support services and crisis intervention services.

"AFDC" means the former Aid to Families with Dependent Children program.

"AFDC-related Medicaid" means medical assistance provided to families who would otherwise qualify for AFDC or would be deemed to qualify for AFDC if the program would be deemed still in existence.

"American Indian/Alaska Native (AI/AN)" means a member of a Federally recognized Indian tribe, band, or group; an Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 C.F.R. 1601 et seq.; or a person who is considered by the Secretary of the Interior as meeting the requirements of tribal membership in accordance with 42 C.F.R. 36a.16.

"Beneficiary or eligible beneficiary" means any person meeting the definition of recipient as defined below.

"Centers for Medicare and Medicaid Services (CMS)" means the agency of the Federal Department of Health and Human Services which is responsible for the administration of the Medicaid program in the United States.

"Commissioner of DHS" means the Commissioner of the Department of Human Services.

"Community residences for mentally ill adults" means any community residential program licensed by the Division of Mental Health Services in accordance with N.J.A.C. 10:37A. "Community residences for mentally ill adults" does not include supportive housing residences as defined at N.J.A.C. 10:37A–1.2 and 10:77A–1.2.

"Copayment" means a specified dollar amount required to be paid by or on behalf of the beneficiary in connection with benefits as specified in N.J.A.C. 10:49–9.1.

"County board of social services (CBOSS)" means that agency of county government which is charged with the responsibility for determining eligibility for public assistance programs including AFDC–Related Medicaid, Temporary Assistance to Needy Families, the Food Stamp program and Medicaid. Depending on the county, the CBOSS might be identified as the Board of Social Services, the Welfare Board, the Division of Welfare, or the Division of Social Services.

"Department" or "DHS" means the Department of Human Services. The Department of Human Services is the single state agency designated by N.J.S.A. 30:4D–3 in accordance with 42 C.F.R. 412.30.

"DHSS" means the Department of Health and Senior Services.

"Division" or "DMAHS" means the Division of Medical Assistance and Health Services.

"DMHS" means the Division of Mental Health Services within the New Jersey Department of Human Services.

"DYFS" means the Division of Youth and Family Services within the New Jersey Department of Human Services.

"Fiscal agent" means an entity that processes and adjudicates provider claims on behalf of programs administered in whole or part by the Division.

"Managed care service administrator" means an entity in a non-risk based financial arrangement that contracts to provide a designated set of services for an administrative fee. Services provided may include, but are not limited to: medical management, claims processing, and provider network maintenance.

"Medicaid" means medical assistance provided to certain persons with low income and limited resources as authorized under Title XIX (Medicaid) of the Social Security Act.

"Medicaid Agent" means, under Reorganization Plan No. 001–1996, either DHSS or DMAHS, acting as administrators of the Medicaid program.

"Mental health rehabilitation services" means psychiatric and psychological services, including emotional and/or behavioral treatment, drug and alcohol dependency treatment, psychiatric treatment, psychotherapy and related nursing services.

"NJ FamilyCare" means the health insurance coverage program administered by DMAHS under the provisions of Title XIX and Title XXI of the Social Security Act.

"NJ FamilyCare–Plan A" means the State-operated program which provides comprehensive, managed care coverage, including all benefits provided through the New Jersey Care ... Special Medicaid Programs, to eligible children through the age of 18, and adults with family incomes up to and including 133 percent of the Federal poverty level.

"NJ FamilyCare–Plan B" means the State-operated program which provides comprehensive, managed care coverage to uninsured children through the age of 18 with family incomes above 133 percent and not in excess of 150 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access mental health and substance abuse services and certain other services which are paid fee-for-service.

"NJ FamilyCare–Plan C" means the State-operated program which provides comprehensive, managed care coverage to uninsured children through the age of 18 with family incomes above 150 percent and not in excess of 200 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access mental health and substance abuse services and certain other services which are paid fee-for-service. Eligibles are required to participate in cost-sharing in the form of monthly premiums and personal contributions to care for certain services.

"NJ FamilyCare–Plan D" means the State-operated program which provides managed care coverage to uninsured children through the age of 18 and adults with gross family incomes above 200 percent and not in excess of 350 percent of the Federal poverty level. In addition to covered managed care services, eligibles may access certain services including mental health and substance abuse services, with limitations, which are paid fee-for-service. Eligibles participate in cost-sharing in the form of monthly premiums and copayments for most services.

"NJ FamilyCare Plan D for adults" means the State-operated program which provides a benefit package through managed care organizations, supplemented by services provided on a fee-for-service basis, to specified parents/caretakers of children enrolled in NJ FamilyCare, in accordance with N.J.A.C. 10:49–5.7, 10:78–7.1 and this chapter.

"NJ FamilyCare Plan I" means the State-operated program which provides a Plan D benefit package on a fee-for-service basis to specified parents/caretakers of children enrolled in NJ FamilyCare, in accordance with N.J.A.C. 10:78–7.1 and this chapter.

"Prepaid health plan" means an entity that provides medical services to enrollees under a contract with DMAHS on the basis of prepaid capitation fees but which does not necessarily qualify as an HMO. For rules concerning prepaid health care services, see N.J.A.C. 10:49–1.1. For Medicaid Managed Care Program—New Jersey Care 2000, see N.J.A.C. 10:49–21.

"Program" means the New Jersey Medicaid program.

"Programs" means the New Jersey Medicaid program and the NJ FamilyCare program.

"Programs of Assertive Community Treatment (PACT)" means mental health rehabilitative services which are delivered in a self-contained treatment program, provided by a service delivery team and managed by a qualified program director, that merge clinical and rehabilitative expertise to provide mental health treatment, rehabilitation, and support services which are individualized and tailored to the unique needs and choices of the individual receiving the services.

"Provider" means any individual, partnership, association, corporation, institution, or any other public or private entity, agency, or business concern, meeting applicable requirements and standards for participation in the New Jersey Medicaid Program, other Special programs, and where applicable, holding a current valid license, and lawfully providing medical care, services, goods and supplies authorized under N.J.S.A. 30:4D–l et seq. and amendments thereto.

"Qualified applicant" means a person who is a resident of this State and is determined to need medical care and services as provided under the Medical Assistance and Health Services Act, N.J.S.A. 30:4D–1 et seq., and who meets one of the eligibility criteria set out therein.

"Recipient" means a qualified applicant receiving benefits under the Medical Assistance and Health Services Act, N.J.S.A. 30:4D–1 et seq.

"Temporary Assistance to Needy Families (TANF)" means that program administered by the Division of Family Development within the Department of Human Services in accordance with N.J.A.C. 10:90.

Recodified from N.J.A.C. 10:49–1.2(a) and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Deleted (a) designation, added "Aid to Families with Dependent Children (AFDC)", "Beneficiary or eligible beneficiary", "Commissioner of DHS", "Department", "Division", "DHSS", "Health Care Financing Agency", "Medicaid Agent", "Prepaid health plan", "Program", and "Qualified applicant"; changed "County welfare agency" to "County welfare agency or CWA" and amended; amended "Provider" and "recipient"; and deleted (b) and (c). Former section, "Early and Periodic Screening, Diagnosis and Treatment (EPSDT)", repealed.

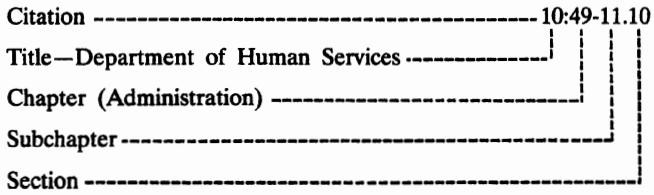
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In "Fiscal agent" inserted a reference to the NJ KidCare program; and inserted "NJ KidCare", "NJ KidCare—Plan A", and "Programs".
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Inserted "NJ KidCare–Plan B" and "NJ KidCare–Plan C".
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.
Amended by R.1999 d.211, effective July 6, 1999 (operative August 1. 1999).
See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).
Added definitions of "Copayment" and "NJ KidCare–Plan D".
Amended by R.2001 d.144, effective May 7, 2001.
See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).
Inserted "DMHS", "DYFS" and "Mental health rehabilitation services".
Amended by R.2002 d.371, effective November 18, 2002.
See: 34 N.J.R. 2244(a), 34 N.J.R. 2549(b), 34 N.J.R. 3978(a).
Added "American Indian/Alaska Native (AI/AN)".
Amended by R.2003 d.81 and 82, effective February 18, 2003.
See: 34 N.J.R. 2647(a), 2650(a), 35 N.J.R. 1116(a), 1118(a).
Rewrote the section.
Special amendment, R.2003 d.98, effective January 31, 2003.
See: 35 N.J.R. 1303(a).
Inserted "NJ FamilyCare Plan D for adults" and "NJ FamilyCare Plan I".
Amended by R.2003 d.89, effective March 3, 2003.
See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).
Added "Programs of Assertive Community Treatment (PACT)".
Special amendment, R.2003 d.417, effective September 26, 2003 (operative November 1, 2003).
See: 35 N.J.R. 4913(a).
Added "Managed care service administrator".
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
Added "Adult mental health rehabilitation services provided in/by community residence programs" and "Community residences for mentally ill adults".

10:49–1.4 Overview of provider manuals

(a) The Medicaid Fiscal Agent and the Division of Medical Assistance and Health Services maintain New Jersey Medicaid and NJ FamilyCare provider manuals. Each is designed for use by a specific type of provider that provides services to Medicaid and/or NJ FamilyCare beneficiaries. Each manual is written in accordance with Federal and State laws, rules, and regulations, with the intent to ensure that such laws, rules, and regulations are uniformly applied.

(b) Each provider manual consists of two chapters, broken down into subchapters. The first chapter is referred to as N.J.A.C. 10:49, Administration Manual, and outlines the general administrative policies of the New Jersey Medicaid program and other special programs including NJ FamilyCare. The second chapter of each manual specifies the rules and regulations relevant to the specific provider-type and the services provided. Following the second chapter of the manuals is the Fiscal Agent Billing Supplement.

(c) Codification of manual material follows that of the New Jersey Administrative Code (N.J.A.C.). The citation for a particular section of the provider manual reflects the same material under the same citation in the N.J.A.C. The following is an example of a citation in the N.J.A.C. or a provider manual:



(d) There is an individual Program provider manual for each of the following services. These services are listed in the New Jersey Administrative Code (N.J.A.C.) under Title 10 (Department of Human Services) Chapters 10:50 through 10:75, and 10:77 through 10:79 as follows:

1. 10:50—Transportation Services Manual
2. 10:51—Pharmacy Services Manual
3. 10:52—Hospital Services Manual
4. 10:53—(Reserved)
5. 10:53A—Hospice Services Manual
6. 10:54—Physician Services Manual
7. 10:55—Prosthetic and Orthotic Services Manual
8. 10:56—Dental Services Manual
9. 10:57—Podiatry Services Manual
10. 10:58—Nurse-Midwifery Services Manual
11. 10:58A—Certified Nurse Practitioner/Clinical Nurse Specialist
12. 10:59—Medical Supplier Services Manual
13. 10:60—Home Care Services Manual
14. 10:61—Independent Clinical Laboratory Services Manual
15. 10:62—Vision Care Services Manual
16. 10:63—Long Term Care Services Manual
17. 10:64—Hearing Aid Services Manual
18. 10:65—Medical Day Care Services Manual
19. 10:66—Independent Clinic Services Manual
20. 10:67—Psychological Services Manual
21. 10:68—Chiropractic Services Manual
22. 10:69 AFDC–Related Medicaid
23. 10:70 Medically Needy Manual
24. 10:71 Medicaid Only Manual
25. 10:72 New Jersey Care ... Special Medicaid Programs Manual
26. 10:73—Case Management Services Manual
27. 10:74—Managed Health Care Services for Medicaid Eligibles
28. 10:75 Programs of Assertive Community Treatment
29. (Reserved)
30. 10:77 Rehabilitation Services Manual
31. 10:78 NJ FamilyCare Manual
32. 10:79 NJ KidCare Manual

(e) Manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the New Jersey Medicaid or NJ FamilyCare program. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding manual updates. Newsletters should be filed at the back of the manual and replacement pages should be added to the manual in accordance with instructions provided. Substantive manual revisions shall be made through the rulemaking process, in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq.

(f) This manual and all subsequent updates are distributed as a guide to assist providers in their participation in the New Jersey Medicaid or NJ FamilyCare program. The provider is ultimately responsible for knowing and abiding by current Federal and State laws and regulations pertaining to this program.

Recodified from N.J.A.C. 10:49–1.8 and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
In (a), substituted "The New Jersey Medicaid Program maintains" for "There are 19" and "Medicaid beneficiaries" for "Medicaid recipients"; in (d), inserted additional N.J.A.C. references; inserted new (d)5, 11 and 23; recodified former (d)5 through 9 and 10 through 20 as (d)6 through 10 and 12 through 22; and in (e), substituted "Substantive manual revisions shall be made" for "Manual revisions shall be substantially made". Former section, "HealthStart", repealed.
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Inserted references to NJ KidCare and made corresponding language changes throughout; and in (a), substituted a reference to the Medicaid Agent and the Division of Medical Assistance and Health Services for a reference to the New Jersey Medicaid Program in the first sentence.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
Rewrote (d).

Case Notes

Extended care facility could not be reimbursed for care for Medicaid-ineligible patient. V.F. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 29.

10:49–1.5 (Reserved)

Repealed by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Section was "Prepaid health plans".

10:49–1.6 (Reserved)

Recodified to N.J.A.C. 10:49–22.3 and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

10:49–1.7 (Reserved)

Repealed by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Section was "State funded programs".

10:49–1.8 (Reserved)

Recodified to N.J.A.C. 10:49–1.4 and amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

SUBCHAPTER 2. NEW JERSEY MEDICAID BENEFICIARIES

10:49–2.1 Who is eligible for Medicaid?

Medicaid beneficiaries are: those eligible for all services under the regular New Jersey Medicaid program (see N.J.A.C. 10:49–2.2 below); those eligible for a limited range of services under the Medically Needy program (see N.J.A.C. 10:49–2.3 below) and those eligible for a limited range of services under the Home and Community–Based Services Waiver Programs, in accordance with N.J.A.C. 10:49–22.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

1. As a condition of continued participation in the New Jersey Medicaid and NJ FamilyCare programs, a provider may, from time to time, be required to:

i. Complete a provider reenrollment application form and sign a provider participation agreement; and/or

ii. Complete a Form HCFA 1513, Ownership and Control Interest Disclosure Statement.

2. The New Jersey Medicaid program or NJ FamilyCare program shall terminate any existing agreement or contract if the provider fails to disclose information required by (b)1ii above.

3. Enrollment documentation requested by the New Jersey Medicaid or NJ FamilyCare program shall be furnished within 35 calendar days of the date of the written request.

(c) An out-of-State provider shall have a current, approved provider agreement with the New Jersey Medicaid or NJ FamilyCare program and hold a current, valid certification and/or license from the appropriate agency under the laws of the respective state in which the provider is located.

(d) A provider application may be requested from the fiscal agent of the New Jersey Medicaid and NJ FamilyCare program. An appropriate program enrollment package will be mailed to the requesting provider. The enrollment application must be completed in full and returned to the fiscal agent, along with all the necessary attachments.

1. The applicant's eligibility to participate in the New Jersey Medicaid and NJ FamilyCare program will be confirmed in writing. A provider number will be assigned and returned to the applicant along with the appropriate program Provider Manual.

2. If the application is denied, the applicant will receive a notification which explains the decision to deny and the applicant's right to appeal the decision (see N.J.A.C. 10:49–10).

(e) If a provider is found to be currently enrolled, but has been inactive for at least two (2) years, the applicant will be required to complete a new application. If the application is approved, the provider's existing record on the Provider Master File will be reactivated.

(f) The New Jersey Medicaid program or NJ FamilyCare program may refuse to enter into or to renew a provider participation agreement with any applicant or provider who has been suspended, debarred, disqualified, or excluded by the Title XIX or Title XXI program of another state. The program may terminate any existing agreement with a provider, if good cause for exclusion of the provider from program participation exists under any of the provisions of N.J.A.C. 10:49–11.1(d)1 through 27.

(g) The New Jersey Medicaid program or NJ FamilyCare program shall not enter into a provider participation agreement with an applicant who has been suspended or excluded from participation in the delivery of medical care or services under Medicare (Title XVIII), Medicaid (Title XIX), or the Social Services Block Grant Act (Title XX) of the Federal Social Security Act, by the Secretary of the United States Department of Health and Human Services.

(h) The Division may place a moratorium on the enrollment of new providers for particular provider types and/or in particular geographic areas if it determines that beneficiary access to services would not be adversely affected, and:

1. That the number of providers already enrolled is sufficient to adequately serve beneficiaries;

2. That a moratorium is necessary in order to address fraud and/or abuse; or

3. That other compelling reasons warrant a moratorium.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
In (b)1i, inserted "reenrollment"; and in (f) and (g), substituted "New Jersey Medicaid program" for "Division".
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Inserted references to NJ KidCare and made corresponding language changes throughout; and in (b) and (f), substituted references to Title XIX and Title XXI for references to Medicaid.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
Rewrote the section.

Cross References

Eye care providers, fulfillment of enrollment process as under this section, see N.J.A.C. 10:62–2.3.

10:49–3.3 Providers with multi-locations

(a) All providers participating in the Medicaid or NJ FamilyCare program shall identify all locations from which they are providing services to Medicaid or NJ FamilyCare beneficiaries.

(b) Each location shall comply with provider participation requirements and shall be assigned a separate provider number. Services rendered to Medicaid or NJ FamilyCare beneficiaries at a location not approved for participation are not eligible for Medicaid or NJ FamilyCare reimbursement.

(c) Billing through a central location for approved multi-location providers shall be allowed; however, providers shall utilize the applicable provider number for each service location. Selection of central or localized billing shall be left to providers, who shall state their preference on the application. The program reserves the right to assign unique provider numbers to maintain the accountability and integrity of the New Jersey Medicaid Management Information System (NJMMIS) and the New Jersey Medicaid or NJ FamilyCare program.

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Rewrote (a) and (b); and substantially amended (c).
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Inserted references to NJ KidCare throughout, and made a corresponding language change.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.

Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

10:49–3.4 Medicaid or NJ FamilyCare provider billing number

(a) A seven digit Provider Billing Number shall be assigned by the fiscal agent to all providers approved for participation. The Provider Billing Number shall be entered upon all claims submitted in accordance with the instructions in the Fiscal Agent Billing Supplement. The Provider Billing Number should also be referenced in all written and telephone inquiries.

(b) Practitioners, as defined in (c)1 below, approved for participation, shall also be assigned a seven digit Provider Servicing Number by the Program fiscal agent. The Provider Servicing Number is an identification number which shall be entered upon all claim submittals in accordance with the instructions in the Fiscal Agent Billing Supplement.

(c) Providers who, for billing purposes, need a referring, ordering or prescribing practitioner's individual Provider Servicing Number, shall contact that practitioner or the fiscal agent, or shall access the Provider Servicing Number Directory, to obtain the number. A practitioner who does not participate in the Medicaid or NJ FamilyCare program will not have a Provider Servicing Number. In the absence of the referring, ordering or prescribing practitioner's individual Provider Servicing Number, providers must enter seven fives (5's) for non-participating out-of-State providers or seven sixes (6's) for non-participating in-State providers to indicate non-participation in the New Jersey Medicaid or NJ FamilyCare program. Providers may contact the Medicaid/NJ FamilyCare Fiscal Agent for a copy of the participating provider directory. In addition, providers may obtain servicing and prescribing numbers at www.njmmis.com.

1. Each participating practitioner (that is, physician, certified nurse midwife, certified nurse practitioner/clinical nurse specialist, chiropractor, dentist, optometrist, podiatrist, or psychologist) shall supply his or her individual Provider Servicing Number to other providers when referring a Medicaid or NJ FamilyCare beneficiary for services, or ordering or prescribing on his behalf.

(d) A shared health care facility (SHCF) (see N.J.A.C. 10:49–4.1) is assigned a registration code (Shared Health Care Facility Number), which must appear on a claim form submitted to the fiscal agent by every member of the SHCF. In addition, each practitioner rendering a service in a shared health care facility must indicate his or her Provider Billing Number and individual Provider Servicing Number on the claim form (see Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Rewrote (a) and (b); and in (c)1, inserted reference to certified nurse practitioner/clinical nurse specialist.
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Inserted references to NJ KidCare and made corresponding language changes throughout.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 with changes, effective August 17, 1998.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
Rewrote (c).

SUBCHAPTER 4. PROVIDERS' ROLE IN A SHARED HEALTH CARE FACILITY

10:49–4.1 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

"Discipline" means a branch of instruction or learning, such as medicine, dentistry, chiropractic, and so forth.

"Patient" means anyone eligible to receive benefits from the program.

"Purveyor" means any person, firm, corporation or other entity other than a provider who, whether or not located in a building which houses a shared health care facility, directly or indirectly, engages in the business of supplying to ultimate users or providers within the shared health care facility any medical supplies, equipment and/or services for which reimbursement under the program is received, including, but not limited to, clinical laboratory services or supplies; diagnostic radiology services; sick room supplies; physical therapy services or equipment; orthopedic or surgical appliances or supplies; drugs, medication or medical supplies; eyeglasses, lenses or other optical supplies or equipment; hearing aids or devices; and any other goods, services, supplies, equipment or procedures prescribed, ordered, recommended or suggested for medical diagnosis, care or treatment, and which amount to $10,000 per year.

"Shared health care facility" (SHCF) means four or more providers, two or more of whom are practicing within different specialties and/or disciplines, either independently or in association with each other, within a single structure; and

1. Two or more of whom share any of the following:
   i. Common waiting areas;
   ii. Examining rooms;
   iii. Treatment rooms;
   iv. Equipment;
   v. Supporting staff;

xi. A statement as to whether or not the patient is expected to return for further treatment.

5. The Division shall have the right to inspect the business records, patient records, leases and other contracts executed by any provider in a shared health care facility. Such inspections may be by site visits to the shared health care facility.

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In (a)4i, substituted a reference to Program Numbers for a reference to Medicaid Numbers.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 without change.

SUBCHAPTER 5. SERVICES COVERED BY MEDICAID AND THE NJ FAMILYCARE PROGRAMS

10:49–5.1 Requirements for provision of services

(a) The services listed in N.J.A.C. 10:49–5.2 are available to beneficiaries eligible for the regular New Jersey Medicaid or the NJ FamilyCare–Plan A programs. Services available to Medically Needy beneficiaries are listed in N.J.A.C. 10:49–5.3. The services listed in N.J.A.C. 10:49–5.2 and 5.3 shall be provided in conjunction with program requirements specifically outlined in the second chapter of each Provider Services Manual.

1. Any service limitations imposed will be consistent with the medical necessity of the patient's condition as determined by the attending physician or other practitioner and in accordance with standards generally recognized by health professionals and promulgated through the New Jersey Medicaid program. Some services require prior authorization from the program before the services are provided (see N.J.A.C. 10:49–6—Authorization Required).

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
In (a), substituted "beneficiaries" for "recipients"; and in (a)1, inserted "prior" preceding "authorization".
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (a), inserted a reference to NJ KidCare—Plan A programs in the first sentence.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

Case Notes

Phalloplasty was medically required treatment for gender dysphoria. M.K. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 38.

Patient's possible Munchausen's syndrome was good cause for limiting medical services. D.S. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 4.

10:49–5.2 Services available to beneficiaries eligible for, or children who are presumptively eligible for, the regular Medicaid and NJ FamilyCare–Plan A programs

(a) The services listed below are available to beneficiaries eligible for the regular Medicaid/NJ FamilyCare–Plan A programs:

1. Case management services (Mental Health Program);

2. Certified nurse practitioner/clinical nurse specialist services;

3. Chiropractic services;

4. Religious non-medical health care services, (see Hospital Services Manual);

5. Clinic services such as services in an independent outpatient health care facility, other than hospital, that provides services such as Mental Health, Family Planning, Dental, Optometric, Ambulatory Surgery, FQHCs;

6. Dental services;

7. Environmental lead inspection services-rehabilitative services;

8. Early and Periodic Screening, Diagnosis, and Treatment for beneficiaries under age 21 (EPSDT): A preventative health care program for beneficiaries under age 21 designed for early detection, diagnosis and treatment of correctable abnormalities. This program supplements the general medical services otherwise available;

9. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey Medicaid or NJ FamilyCare–Plan A program.

10. HealthStart maternity and pediatric care services include packages of comprehensive medical and health support services provided by independent clinics; hospital outpatient departments; local health departments meeting New Jersey Department of Health and Senior Services' improved pregnancy outcome criteria; physicians; and nurse midwives; either directly or through linkage with other HealthStart care providers. (See N.J.A.C. 10:49–19 for HealthStart services, policies and requirements for provider participation;)

11. Hearing aid services;

12. Home care services (home health care and personal care assistant services);

13. Hospice services including room and board services in a nursing facility (available to dually eligible Medicare/Medicaid or dually eligible Medicare/NJ FamilyCare–Plan A beneficiaries);

14. Hospital services—inpatient:

i. General hospitals;

ii. Special hospitals;

iii. Psychiatric hospitals (inpatient): Limited to persons age 65 or older and children 21 years of age and under; and

iv. Inpatient psychiatric programs for children 21 years of age and under;

15. Hospital services—outpatient;

16. Laboratory (clinical);

17. Medical day care services;

18. Medical supplies and equipment;

19. Mental health services, including mental health rehabilitation services provided in:

i. Residential child care facilities (see N.J.A.C. 10:77 and 10:127);

ii. Children's group homes (see N.J.A.C. 10:77 and 10:128);

iii. Psychiatric community residences for youth (see N.J.A.C. 10:37B and 10:77);

iv. Behavioral assistance services for children/youth or young adults under EPSDT (see N.J.A.C. 10:77–4);

v. Programs for Assertive Community Treatment (PACT) Services (see N.J.A.C. 10:37J and 10:76); and

vi. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:37A and 10:77A).

20. Nursing facility services, including intermediate care facilities for the mentally retarded;

i. Any additional Intermediate Care Facility/Mental Retardation (ICF/MR) beds or new ICF/MR facilities shall be approved by the Division of Developmental Disabilities (DDD) prior to application for reimbursement as a Medicaid/NJ FamilyCare provider;

21. Nurse-midwifery services;

22. Optometric services;

23. Optical appliances;

24. Pharmaceutical services;

25. Physician services;

26. Podiatric services;

27. Prosthetic and orthotic devices;

28. Psychological services;

29. Radiological services;

30. Rehabilitative services (Payments are made to eligible Medicaid/NJ FamilyCare–Plan A providers only. No payment is made to privately practicing therapists);

i. Physical therapy, as provided by a home health agency, independent clinic, nursing facility, hospital outpatient department, or in a physician's office;

ii. Occupational therapy, as provided by a home health agency, independent clinic, nursing facility, or hospital outpatient department;

iii. Speech-language pathology services, as provided by a home health agency, independent clinic, nursing facility, hospital outpatient department, or in a physician's office;

iv. Audiology services provided in the office of a licensed specialist in otology or otolaryngology, or as part of independent clinic or hospital outpatient services; and

v. School based rehabilitation services under EPSDT; and

31. Transportation services which include ambulance, mobility assistance vehicle, and other transportation provided by independent clinics or through arrangements with a county board of social services.

(b) All Medicaid and NJ FamilyCare Plan A beneficiaries shall be eligible to receive all of the services specified in (a) above fee-for-service during the presumptive eligibility period, and through the time that they select and are enrolled into a managed care organization, if managed care is applicable.

Amended by R.1994 d.600, effective December 5, 1994.
See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).
Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Amended section name; substituted "beneficiaries" for "recipients" throughout; in (a)4, inserted reference to FQHCs; in (a)8, amended Department name and N.J.A.C. reference; and in (a)28, deleted reference to livery transportation.
Amended by R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
In (a), inserted references to NJ KidCare—Plan A throughout.
Amended by R.1998 d.143, effective March 16, 1998.
See: 29 N.J.R. 543(a), 30 N.J.R. 1081(a).
In (a), inserted a new 6, and recodified former 6 through 28 as 7 through 29.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.2000 d.266, effective July 3, 2000.
See: 32 N.J.R. 159(a), 32 N.J.R. 2493(a).

Added (b).
Amended by R.2000 d.309, effective August 7, 2000.
See: 32 N.J.R. 1342(a), 32 N.J.R. 2900(a).
In (a), inserted a new 2, recodified former 2 through 26 as 3 through 27, inserted "services including" in the new 13, inserted a new 28, recodified former 27 through 29 as 29 through 31, added v in the new 30, and substituted a reference to mobility assistance vehicles for a reference to invalid coaches and substituted a reference to county boards of social services for a reference to county welfare agencies in the new 31.
Amended by R.2001 d.144, effective May 7, 2001.
See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).
Rewrote (a)19.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
In (a), substituted "Religious non-medical health care services," for "Christian Science Sanatoria" in 4, added 20i.
Amended by R.2003 d.89, effective March 3, 2003.
See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).
In (a), rewrote 19 and substituted "NJ FamilyCare" for "or KidCare" in 30.
Amended by R.2003 d.479, effective December 15, 2003.
See: 35 N.J.R. 2146(a), 35 N.J.R. 5584(a).
In (a)19, inserted a new iv and recodified former iv as new v and rewrote new v.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (a)19, added vi.

10:49–5.3 Services available to beneficiaries eligible for the Medically Needy program

(a) Regular Medicaid services are available to Medically Needy beneficiaries except for the following services which are not available or are only available to certain eligible Medically Needy groups: (See the service code next to the beneficiary's name on the Medicaid Eligibility Identification Card to ascertain the Medically Needy group under which the beneficiary's eligibility was established; that is, Group A—pregnant women, Group B—needy children, and Group C—aged, blind and disabled.)

1. Chiropractic services are available only to pregnant women (Group A).

2. EPSDT services are not available to any Medically Needy group.

3. Hospital services (inpatient) are available only to pregnant women (Group A).

4. Nursing facility services are available to Medically Needy beneficiaries. For purposes of the Medically Needy program, nursing facility services include pharmacy services under Title XIX.

5. Medical day care services are available only to pregnant women, the aged, the blind and the disabled (Groups A and C).

6. Pharmaceutical services are available only to pregnant women and needy children (Groups A and B); and aged, blind or disabled beneficiaries who reside in Medicaid participating nursing facilities (see N.J.A.C. 10:51–2.10). Pharmaceutical services are not available to other aged, blind and disabled beneficiaries (Group C).

7. Podiatric services are available only to pregnant women, the aged, the blind and the disabled (Groups A and C).

8. Rehabilitative services are not available for reimbursement when provided through a hospital or nursing facility, except to pregnant women as part of their inpatient hospital services.

9. Case management services for the mentally ill are available to Medically Needy pregnant women only.

10. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical or clinic), drugs, laboratory services, radiological and diagnostic services and surgical procedures are not available to the Medically Needy group.

Amended by R.1994 d.600, effective December 5, 1994.
See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).
Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Amended section name; substituted "beneficiaries" and "beneficiary's" for "recipients" or "recipient's" throughout; in (a)4, substituted "beneficiaries" for "group" and inserted reference to pharmacy services; and in (a)6, inserted references to aged, blind or disabled beneficiaries.

Case Notes

Administrative Procedure Act notice requirement violated by freeze on Medicaid reimbursement rate increases. Thomas Jefferson University Hospital v. Div. of Medical Assistance and Health Services, 6 N.J.A.R. 127 (1981).

Hospital not entitled to hearing prior to decertification as Medicaid provider. Preakness Hospital v. Div. of Medical Assistance and Health Services, 3 N.J.A.R. 351 (1981).

Agency action in enforcing its regulations to deny ambulance service claims not arbitrary, capricious and unreasonable (Division's Final Decision). Bergen Ambulance Services v. Hudson Cty. Medical Assistance Unit, 2 N.J.A.R. 196 (1980).

10:49–5.4 Emergency medical services for aliens and prenatal care for specified pregnant alien women

(a) Most legal aliens who entered the United States on or after August 22, 1996 are restricted in their entitlement to emergency services for five years from their date of entry. Undocumented aliens and temporarily documented aliens, that is visitors, workers, and students, are also restricted in their entitlement to emergency services. These emergency medical services are only available to individuals who, except for their alien status, would be eligible for Medicaid, Medically Needy, New Jersey Care ... Special Medicaid Programs, AFDC-related Medicaid, or NJ FamilyCare–Plan A. Applicants who would otherwise be eligible for NJ FamilyCare–Plans B, C and D are not eligible for these emergency medical services for aliens.

1. Except as noted in (a)2 below, emergency services are defined as care provided in an acute care general hospital (emergency outpatient services and/or inpatient services) for a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

i. Placing the patient's health in serious jeopardy;

ii. Serious impairment to bodily functions; or

iii. Serious dysfunction of any bodily organ or part.

2. For labor and delivery services, the place of service is not limited to an acute care general hospital. Services provided in birth centers are also eligible for reimbursement under this program.

3. Diagnoses are classified as emergency or non-emergency services in accordance with the above definition of an emergency. Those diagnoses that correspond with emergency care are defined as emergencies and thus do not require any authorization by the attending physician. Those diagnoses that correspond with urgent care require a Certification of Treatment of Emergency Medical Condition signed by the attending physician confirming the emergency nature of the encounter to be attached to the claim when submitted for reimbursement.

i. Emergency care is provided for life-threatening or organ threatening, or potentially life or organ threatening condition that requires immediate care.

ii. Urgent care is provided for a condition that is potentially harmful to a patient's health and determined by the physician to be medically necessary for treatment within 12 hours to prevent deterioration.

4. To be eligible for emergency services, an alien meeting the medical criteria listed in (a)1 above must also meet all financial and categorical eligibility requirements for NJ FamilyCare–Plan A, Medicaid, Medically Needy, New Jersey Care ... Special Medicaid Programs or AFDC-related Medicaid.

(b) Lawfully admitted aliens who entered the United States prior to August 22, 1996 and other aliens who are refugees, asylees, Cuban/Haitian entrants, American Indians born in Canada, Amerasian immigrants, and aliens who are honorably discharged or are on active duty in the Armed Forces of the United States and their spouses and unmarried dependent children, may qualify for full NJ FamilyCare–Plan A, Medicaid, Medically Needy, New Jersey Care ... Special Medicaid Programs or AFDC-related Medicaid, if they meet all other programmatic eligibility requirements. These aliens should be referred to the appropriate eligibility determination agency of their choice to apply for full benefits. See N.J.A.C. 10:70–3.2(a), 10:71–3.3(c), 10:72–3.2(a), and 10:79–3.2(b).

(c) Legally admitted pregnant alien women who entered the United States on or after August 22, 1996, who would otherwise be eligible for New Jersey Care . . . Special Medicaid Programs, except for the alien requirements are also eligible for routine prenatal care services. Prenatal care includes services provided in the outpatient hospital department, or by a physician, certified nurse practitioner or certified nurse midwife, as well as laboratory, radiological and pharmaceutical services.

New Rule, R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Former N.J.A.C. 10:49–5.4., Services not covered by the Medicaid program, recodified to N.J.A.C. 10:49–5.5.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Amended by R.1999 d.253, effective August 2, 1999.
See: 31 N.J.R. 97(a), 31 N.J.R. 2203(b).
Rewrote the section.
Emergency amendment R.1999 d.254, effective July 12, 1999 (to expire September 10, 1999).
See: 31 N.J.R. 2252(a).
Rewrote the section.
Adopted concurrent proposal, R.1999 d.345, effective September 10, 1999.
See: 31 N.J.R. 2252(a), 31 N.J.R. 2880(a).
Readopted provisions of R.1999 d.254 without change.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
In (a), inserted "in their entitlement" following "restricted" throughout.

10:49–5.5 Services not covered by the Medicaid or NJ FamilyCare–Plan A program

(a) Listed below are some general services and items excluded from payment under the New Jersey Medicaid and NJ FamilyCare–Plan A program. There are additional specific exclusions and limitations detailed in the second chapter of each Provider Services Manual. Payment is not made for the following:

1. Any service, admission, or item, which is not medically required for diagnosis or treatment of a disease, injury, or condition;

2. Services provided to all persons without charge; these services shall not be billed to the Medicaid program when provided for a Medicaid beneficiary. Services and items provided without charge through programs of other public or voluntary agencies (for example, New Jersey State Department of Health and Senior Services, New Jersey Heart Association, First Aid Rescue Squads, and so forth) shall be utilized to the fullest extent possible;

3. Any service or items furnished in connection with elective cosmetic procedures;

i. There are certain exceptions to this rule, but the exceptions require prior authorization. A written certification of medical necessity and a treatment plan shall be submitted by the physician to the appropriate Medicaid District Office for consideration;

4. Private duty nursing services (except for beneficiaries under EPSDT, Model Waiver III, ACCAP and ABC programs);

5. Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military;

6. Services provided outside the United States and territories;

7. Services or items furnished for any condition or accidental injury arising out of and in the course of employment for which any benefits are available under the provisions of any workers' compensation law, temporary disability benefits law, occupational disease law, or similar legislation, whether or not the Medicaid beneficiary claims or receives benefits thereunder, and whether or not any recovery is obtained from a third-party for resulting damages;

8. That part of any benefit which is covered or payable under any health, accident, or other insurance policy (including any benefits payable under the New Jersey no-fault automobile insurance laws), any other private or governmental health benefit system, or through any similar third-party liability, which also includes the provision of the Unsatisfied Claim and Judgment Fund;

9. Services or items furnished prior to or after the period for which the beneficiary presents evidence of eligibility for coverage.

i. Payment is made for inpatient hospital services (excluding governmental psychiatric hospitals) when ineligibility occurs after admission to hospital as an inpatient. Payment is also made for certain services that were authorized and initiated before loss of eligibility such as dental, vision care, prosthetics and orthotics, and durable medical equipment. Also, see "Retroactive Eligibility" at N.J.A.C. 10:49–2.7(c);

10. Any services or items furnished for which the provider does not normally charge;

11. Any admission, service, or item, requiring prior authorization, where prior authorization has not been obtained or has been denied (see N.J.A.C. 10:49–6, Authorizations required);

12. Services furnished by an immediate relative or member of the Medicaid beneficiary's household;

13. Services billed for which the corresponding health care records do not adequately and legibly reflect the requirements of the procedure described or procedure code utilized by the billing provider, as specified in the Provider Services Manual;

i. Final payment shall be made in accordance with a review of those services actually documented in the provider's health care record. Further, the medical necessity for the services must be apparent and the quality of care must be acceptable as determined upon review by an appropriate and qualified health professional consultant.

ii. All such determinations will be based on rules and regulations of the New Jersey Medicaid Program, the minimum requirements described in the appropriate New Jersey Medicaid Provider Services Manual, to include those elements required to be documented in the provider's records according to the procedure code(s) utilized for payment, and on accepted professional standards. (See N.J.A.C. 10:49–9.5, Provider Certification and Recordkeeping.)

iii. Any other evidence of the performance of services shall be admissible for the purpose of proving that services were rendered only if the evidence is found to be clear and convincing. "Clear and convincing evidence" of the performance of services includes, but is not limited to, office records, hospital records, nurses notes, appointment diaries, and beneficiary statements.

iv. Therefore, any difference between the amount paid to the provider based on the claim submitted and the Medicaid Agent's value of the procedure as determined by the Medicaid Agent's evaluation, may be recouped by the Medicaid Agent.

14. Any claim submitted by a provider for service(s) rendered, except in a medical emergency, to a Medicaid or a NJ FamilyCare–Plan A beneficiary whose Medicaid or NJ FamilyCare Eligibility Identification Card has a printed message restricting the beneficiary to another provider of the same service(s). (See N.J.A.C. 10:49–2.13(e)2, Special Status program);

15. Services or items reimbursed based upon submission of a cost study when there are no acceptable records or other evidence to substantiate either the costs allegedly incurred or beneficiary income available to offset those costs. In the absence of financial records, a provider may substantiate costs or available income by means of other evidence acceptable to the Medicaid Agent or the Division. If upon audit, financial records or other acceptable evidence are unavailable for these purposes:

i. All reported costs for which financial records or other acceptable evidence are unavailable for review upon audit are deemed to be non-allowable; and/or

ii. Beneficiary income shall be presumed to equal the maximum income allowable for a Medicaid or NJ FamilyCare beneficiary for those beneficiaries whose records relating to income are completely unavailable;

iii. The Medicaid Agent or the Division shall seek recovery of any resulting overpayments;

16. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical or clinic), drugs, laboratory services, radiological and diagnostic services and surgical procedures;

17. Claims for services, goods or supplies which are furnished, rendered, prescribed or ordered in violation of Federal or State civil or criminal statutes, or in violation of licensure statutes, rules and/or regulations; and

18. Any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the direction or on the prescription of a physician, individual or entity, during the period when such physician, individu-

al or entity is excluded from participation in the Medicaid and NJ FamilyCare programs, and when the physician, individual or entity furnishing such item or service has received written notice from the Division that the physician, individual or entity has been excluded from participation in the Medicaid and NJ FamilyCare programs.

Amended by R.1994 d.600, effective December 5, 1994.
See: 26 N.J.R. 3345(a), 26 N.J.R. 4762(a).
Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).
Amended section name; substituted "beneficiaries" and "beneficiary's" for "recipients" or "recipient's" throughout; in (a)2, inserted "; these services" preceding "shall not be billed" and amended Department name; in (a)4, inserted references to Model Waiver III, ACCAP and ABC programs; in (a)13iv and (a)15, substituted reference to Medicaid Agent for reference to Division.
Recodified from N.J.A.C 10:49–5.4 and amended R.1998 d.116, effective January 30, 1998 (operative February 1, 1998; to expire July 31, 1998).
See: 30 N.J.R. 713(a).
Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
In (a), inserted a reference to the NJ KidCare-Plan A program in the first sentence, inserted a reference to NJ KidCare-Plan A beneficiaries and substituted a reference to NJ KidCare Eligibility Identification Cards for Eligibility Identification Cards in 14, inserted references to the Division throughout 15, and inserted a reference to NJ KidCare beneficiaries in 15ii.
Adopted concurrent proposal, R.1998 d.426, effective July 24, 1998.
See: 30 N.J.R. 713(a), 30 N.J.R. 3034(a).
Readopted provisions of R.1998 d.116 without change.
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
In (a), added 17 and 18.

Cross References

Medical Day Center, verification of recipients eligibility as under this section, see N.J.A.C. 10:65–1.6.

Case Notes

Digital scale for applicant with morbid obesity was not an item for which Medicaid funds were available. R.S. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 65.

Extended care facility could not be reimbursed for care for Medicaid-ineligible patient. V.F. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 29.

Hospital not entitled to hearing prior to decertification as medical provider. Preakness Hospital v. Div. of Medical Assistance and Health Services, 3 N.J.A.R. 351 (1982).

10:49–5.6 Services available and unavailable to beneficiaries eligible for, or who are presumptively eligible for, NJ FamilyCare–Plan B or C

(a) Except for the exceptions at N.J.A.C. 10:79–6.5, which concern services for newborns enrolling into NJ FamilyCare–Plan C, the services listed below are available to beneficiaries eligible for NJ FamilyCare–Plan B or C, through an HMO selected by the NJ FamilyCare–Plan B or C beneficiary.

1. Audiology services;

2. Certified nurse practitioner services;

3. Chiropractic services;

4. Clinic services (services in an independent outpatient health care facility, other than hospital, that provides services such as, dental, optometric, ambulatory surgery, etc.);

5. Clinical nurse specialist services;

6. Dental services;

7. Durable medical equipment;

8. Early and periodic screening, and diagnosis examinations, dental, vision and hearing services. Includes only those treatment services identified through the examination that are available under the HMO contract or covered fee-for-service program;

9. Emergency room services;

10. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling;

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey Medicaid or NJ FamilyCare program.

11. Federally qualified health center primary care services;

12. HealthStart maternity services, which is a package of comprehensive medical and health support services provided by the HMO;

13. Hearing aid services;

14. Home health care services;

i. Exception: personal care assistant services;

15. Hospice services;

16. Hospital services—inpatient:

i. General hospitals;

ii. Special hospitals; and

iii. Rehabilitation hospitals;

17. Hospital services—outpatient;

18. Laboratory (clinical);

19. Medical supplies and equipment;

20. Nurse-midwifery services;

21. Optometric services;

22. Optical appliances;

23. Organ transplant services, except the inpatient hospital services. Inpatient hospital services for organ transplants are covered fee-for-service;

24. Prescription drug services;

25. Physician services;

26. Podiatric services;

27. Prosthetic and orthotic devices;

28. Private duty nursing;

29. Radiological services;

30. Rehabilitative services, including physical, occupational and speech therapy, limited to 60 days per type of therapy per year; and

31. Transportation services, limited to ambulance, MICU's and invalid coach.

(b) The services listed below are available to beneficiaries eligible for NJ FamilyCare–Plan B or C under fee-for-service:

1. Religious non-medical health care institution care and services;

2. Clinic services (services in an independent outpatient health care facility, other than hospital) for family planning services, mental health or substance abuse treatment services;

3. Elective/induced abortion services;

4. Emergency room services for treatment of mental health disorder or for substance abuse;

5. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling;

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered;

6. Hospital services—inpatient;

i. Psychiatric hospitals;

ii. Inpatient psychiatric programs for children 19 years of age and under;

iii. Acute care or special hospital services if provided for mental health or substance abuse services;

iv. Organ transplant hospital services;

(1) All other transplant services are covered by HMO;

7. Mental health services provided by practitioners, such as physicians, psychologists, and certified nurse practitioners/clinical nurse specialists;

8. Nursing facility services, limited to the Medicare Part A copayments for the first 30 days of skilled nursing care;

9. Outpatient hospital services for family planning, mental health and substance abuse treatment services;

10. Substance abuse services provided by practitioners, including physicians, psychologists, certified nurse practitioners/clinical nurse specialists; and

11. Targeted case management services for the chronically ill.

(c) Services not covered under Plan B and C are as follows:

1. Unless listed in (a) and (b) above, no other services are covered by NJ FamilyCare–Plan B or C.

2. Services not covered include, but are not limited to:

i. Nursing facility services, except the Medicare Part A copayments for the first 30 days of skilled nursing care;

ii. Intermediate care facilities for mental retardation (ICFs/MR);

iii. Personal care services;

iv. Medical day care services;

v. Lower mode transportation;

vi. Mental health rehabilitation services provided in residential child care facilities (as defined in N.J.A.C. 10:127 and licensed by DYFS), children's group homes (as defined in N.J.A.C. 10:128 and licensed by DYFS), psychiatric community residences for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS) or behavioral assistance services for children/youth or young adults (see N.J.A.C. 10:77–4);

vii. Any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the direction or on the prescription of a physician, individual or entity, during the period when such physician, individual or entity is excluded from participation in the Medicaid and NJ FamilyCare programs, and when the physician, individual or entity furnishing such item or service has received written notice from the Division that the physician, individual or entity has been excluded from participation in the Medicaid and NJ FamilyCare programs;

viii. Programs for Assertive Community Treatment (PACT) services; and

ix. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:37A and 10:77A).

(d) All presumptively eligible NJ FamilyCare–Plan B and C beneficiaries shall be eligible to receive all the services specified in (a) and (b) above fee-for-service during the presumptive eligibility period, which shall include the services that are otherwise only available through the managed care organizations. The provision of the managed care services fee-for-service shall be limited to the presumptive eligibility period.

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).
Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).
Readopted the provisions of R.1998 d.154 with changes, effective September 21, 1998.
Amended by R.2000 d.266, effective July 3, 2000.
See: 32 N.J.R. 159(a), 32 N.J.R. 2493(a).
Added (d).
Amended by R.2001 d.144, effective May 7, 2001.
See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).
Added (c)2vi.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
In (b)1, substituted "Religious non-medical health care institution" for "Christian Science sanatoria"; in (c), added "for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS); and" at the end of vi and added vii.
Amended by R.2003 d.89, effective March 3, 2003.
See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).
Rewrote (c)2.
Amended by R.2003 d.479, effective December 15, 2003.
See: 35 N.J.R. 2146(a), 35 N.J.R. 5584(a).
In (c)2vi, added "or behavioral assistance services for children/youth or young adults (see N.J.A.C. 10:77–4)" to the end of the paragraph.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (c)2, added ix.

10:49–5.7 Services available and unavailable to beneficiaries eligible for NJ FamilyCare–Plan D

(a) Except as indicated at N.J.A.C. 10:79–2.5, which concerns services for newborns enrolling into NJ FamilyCare–Plan C and D, the services listed below are available to beneficiaries eligible for NJ FamilyCare–Plan D and Plan D for Adults, when medically necessary and provided through the network of an HMO selected by the NJ FamilyCare–Plan D beneficiary.

1. Certified nurse practitioner and clinical nurse specialist services;

2. Clinic services (services in an independent outpatient health care facility, other than hospital, that provides covered ambulatory care services);

3. Preventive dental services for children under the age of 12 years, including oral examinations, oral prophylaxis and topical application of fluorides;

4. Emergency room services;

5. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey FamilyCare program;

6. Federally qualified health center primary care services;

7. Home health care services, limited to skilled nursing for a home bound beneficiary which is provided or supervised by a registered nurse, and home health aide when the purpose of the treatment is skilled care, medical social services which are necessary for the treatment of the beneficiary's medical condition and short-term physical, speech or occupation therapy with the same limitations described in (a)22 below;

i. Personal care assistant services are not covered;

8. Hospice services;

9. Hospital services—inpatient;

10. Hospital services—outpatient;

11. Laboratory (clinical);

12. Nurse-midwifery services;

13. Optometric services, including one routine eye examination per year;

14. Optical appliances, limited to one pair of glasses or contact lenses per 24 month period;

15. Organ transplant services which are non-experimental or non-investigational;

16. Prescription drug services;

i. Exception: Over-the-counter drugs are not covered;

17. Physician services;

18. Podiatric services;

i. Exception: Coverage excludes routine foot care;

19. Prosthetic appliances, limited to initial provision of prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defect;

i. Coverage includes repair and replacement when due to congenital growth;

20. Outpatient surgery;

21. Radiological services;

22. Inpatient rehabilitative services, including physical, occupational and speech therapy for non-chronic conditions and acute illnesses and injuries;

23. Transportation services, limited to ambulance for medical emergency only;

24. Well child care including immunizations, lead screening and treatments;

25. Maternity and related newborn care; and

26. Diabetic supplies and equipment.

(b) The services listed below are available to beneficiaries eligible for NJ FamilyCare-Plan D under fee-for-service.

1. Services for mental health or behavioral conditions;

i. Inpatient hospital services, including psychiatric hospitals, limited to 35 days per year;

ii. Outpatient benefits for short-term, outpatient evaluative and crisis intervention or home health mental health services, limited to 20 visits per year;

(1) When authorized by the Division of Medical Assistance and Health Services, inpatient benefit exchanges are allowed. One mental health inpatient day may be exchanged for up to four outpatient services, including partial care. This is limited to an exchange of up to a maximum of 10 inpatient days for a maximum of 40 additional out patient visits.

(2) When authorized by the Division of Medical Assistance and Health Services, inpatient benefit exchanges are allowed. One mental health inpatient day may be exchanged for two days of treatment in partial hospitalization up to the maximum number of covered inpatient days.

iii. Inpatient and outpatient services for substance abuse are limited to detoxification;

2. Outpatient rehabilitative services, including physical, occupational and speech therapy for non-chronic conditions and acute illnesses and injuries. Outpatient rehabilitation benefits are limited to treatment over a period of 60 consecutive business days per incident of illness or injury beginning with the first day of treatment per contract year, except that:

i. Speech therapy services rendered for treatment of delays in speech development, unless resulting from disease, injury or congenital defects are not covered; and

3. Elective/induced abortion services.

(c) Services not covered under Plan D are as follows:

1. Unless listed in (a) and (b) above, no other services are covered by NJ FamilyCare–Plan D.

2. Services not covered include, but are not limited to:

i. Services that are not medically necessary;

ii. Private duty nursing unless authorized by the HMO;

iii. Intermediate care facilities for mental retardation (ICF/MR);

iv. Personal care assistant services;

v. Medical day care services;

vi. Chiropractic services;

vii. Dental services except for preventive dentistry for children under age 12;

viii. Orthotic devices;

ix. Targeted case management for the chronically ill;

x. Inpatient psychiatric programs for children age 19 years and under;

xi. Religious non-medical health care institution care and services;

xii. Durable medical equipment;

xiii. EPSDT services;

(1) Refer to (a)24 above concerning the coverage of well child care including immunizations, lead screening and treatments;

xiv. Routine transportation, including nonemergency ambulance, invalid coach and lower mode transportation;

xv. Hearing aid services;

xvi. Blood and blood plasma;

(1) Administration, processing of blood, processing fees and fees related to autologous blood donations are covered;

xvii. Cosmetic services;

xviii. Custodial care;

xix. Special and remedial educational services;

xx. Experimental and investigational services;

xxi. Infertility services;

xxii. Medical supplies;

(1) Diabetic supplies are a covered service;

xxiii. Rehabilitative services for substance abuse;

xxiv. Weight reduction programs or dietary supplements;

(1) Surgical operations, procedures or treatment of obesity, shall not be covered, except when specifically approved by the HMO;

xxv. Acupuncture and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery;

xxvi. Temporomandibular joint disorder (TMJ) treatment, including treatment performed by prosthesis placed directly in the teeth;

xxvii. Nursing facility (long term care) services;

xxviii. Recreational therapy;

xxix. Sleep therapy;

xxx. Court ordered services;

xxxi. Thermograms and thermography;

xxxii. Biofeedback;

xxxiii. Radial keratotomy;

xxxiv. Mental health rehabilitation services provided in residential child care facilities (as defined in N.J.A.C. 10:127 and licensed by DYFS), children's group homes (as defined in N.J.A.C. 10:128 and licensed by DYFS), psychiatric community residences for youth (as defined in N.J.A.C. 10:37B and licensed by DMHS) or behavioral assistance services for children/youth or young adults (see N.J.A.C. 10:77–4);

xxxv. Respite care;

xxxvi. Any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the direction or on the prescription of a physician, individual or entity, during the period when such physician, individual or entity is excluded from participation in the Medicaid and NJ FamilyCare programs, and when the physician, individual or entity furnishing such item or service has received written notice from the Division that the physician, individual or entity has been excluded from participation in the Medicaid and NJ FamilyCare programs;

xxxvii. Programs for Assertive Community Treatment (PACT) services; and

xxxviii. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:37A and 10:77A).

New Rule, R.1999 d.211, effective July 6, 1999 (operative August 1, 1999).
See: 31 N.J.R. 998(a), 31 N.J.R. 1806(a), 31 N.J.R. 2879(b).
Amended by R.2001 d.144, effective May 7, 2001.
See: 32 N.J.R. 4387(a), 33 N.J.R. 1378(b).
Added (c)2xxxiv.
Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).
In (c)2, substituted "Religious non-medical health care institution" for "Christian science sanatoria" in xi and added xxxiv.
Special amendment, R.2003 d.98, effective January 31, 2003.
See: 35 N.J.R. 1303(a).
Rewrote (c)2.
Amended by R.2003 d.89, effective March 3, 2003.
See: 34 N.J.R. 1593(a), 35 N.J.R. 1281(a).
In (c)2, added xxxvi and xxxvii.
Amended by R.2003 d.479, effective December 15, 2003.
See: 35 N.J.R. 2146(a), 35 N.J.R. 5584(a).
In (c)2xxxiv, inserted "or behavioral assistance services for children/youth or young adults (see N.J.A.C. 10:77–4)" at the end of the paragraph.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (c)2, added xxxviii.

10:49–5.8 Services available for beneficiaries eligible for NJ FamilyCare–Plan H

(a) Childless adults whose income is below 100 percent of the Federal poverty level and who do not qualify for WFNJ/GA and who are enrolled in NJ FamilyCare on July 1, 2002 shall be eligible to receive the NJ FamilyCare Plan H service package.

(b) Restricted alien parents who are enrolled in NJ FamilyCare on November 1, 2003, shall receive the Plan H service package.

(c) Out-of-plan community-based mental health services shall be limited to 60 service days per calendar year and shall be eligible for payment on a fee-for-service basis.

1. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:77A) shall not be eligible for payment under NJ FamilyCare–Plan H.

(d) No behavioral health out-of-plan service of any kind, where the place of service is a hospital, shall be a covered service.

(e) The services listed below shall be available to beneficiaries eligible for NJ FamilyCare Plan H, when medically necessary and when provided through the network of a managed care service administrator selected by the beneficiary:

1. Ambulance—medical emergency only;

2. Ambulatory surgery in an outpatient hospital setting only;

3. Certified nurse practitioner/clinical nurse specialist;

4. Clinic services (free standing)—ambulatory;

5. Diabetic supplies/equipment;

6. Durable Medical equipment-limited benefit, only covered when a medically necessary part of the beneficiary's inpatient hospital discharge plan;

7. Emergency room services;

8. Federally qualified health centers (FQHC) primary care services;

9. Home health care services (limited benefits);

10. Inpatient hospital (non-behavioral health related);

11. Laboratory services;

12. Outpatient hospital (non-mental health related);

13. Physician services;

14. Prescription drugs (excludes over the counter medications; and

15. Radiological services.

(f) The following services shall be available to NJ FamilyCare–Plan H beneficiaries on a fee-for-service basis:

1. Abortion (elective/induced); and

2. Mental health services in the community, including psychological services, up to a maximum of 60 days per calendar year;

i. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:77A) are not eligible for payment under NJ FamilyCare–Plan H.

Special New Rule, R.2002 d.214, effective June 10, 2002.
See: 34 N.J.R. 2338(a).
Special amendment, R.2003 d.417, effective September 26, 2003 (operative November 1, 2003).
See: 35 N.J.R. 4913(a).
Rewrote the section.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (c), added 1; in (f), added 2i.

10:49–5.9 Services available for beneficiaries eligible for NJ FamilyCare Plan G

General Assistance-eligible individuals shall receive Plan G services, which shall be those services delineated at N.J.A.C. 10:49–24.3.

Special New Rule, R.2002 d.214, effective June 10, 2002.
See: 34 N.J.R. 2338(a).

10:49–5.10 Services available to beneficiaries eligible for NJ FamilyCare–Plan I

(a) The services listed below are available to beneficiaries eligible for NJ Family Care–Plan I, on a fee-for-service basis, when medically necessary:

1. Certified nurse practitioner and clinical nurse specialist services;

2. Clinic services (services in an independent outpatient health care facility, other than a hospital, that provides covered ambulatory care services);

3. Emergency room services;

4. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures shall not be covered by the NJ FamilyCare program;

5. Federally qualified health center primary care services;

6. Home health care services, limited to skilled nursing for a home bound beneficiary which is provided or supervised by a registered nurse, and home health aid services when the purpose of the treatment is skilled care; medical social services which are necessary for the treatment of the beneficiary's medical condition; and short-term physical, speech or occupation therapy with the same limitations described in (a)21 below;

i. Personal care assistant services are not covered;

7. Hospice services;

8. Hospital services—inpatient;

9. Hospital services—outpatient;

10. Laboratory (clinical);

11. Nurse-midwifery services;

12. Optometric services, including one routine eye examination per year;

13. Optical appliances, limited to one pair of glasses or contact lenses per 24 month period;

14. Organ transplant services which are non-experimental or non-investigational;

15. Prescription drug services, except that over-the-counter drugs are not covered;

16. Physician services;

17. Podiatric services, except that routine foot care is not covered;

18. Prosthetic appliances, limited to initial provision of prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defect;

i. Coverage includes repair and replacement when due to congenital growth;

19. Outpatient surgery;

20. Radiological services;

21. Outpatient rehabilitative services, including physical, occupational and speech therapy for non-chronic conditions and acute illnesses and injuries. Outpatient rehabilitation benefits are limited to treatment over a period of 60 consecutive business days per incident of illness or injury beginning with the first day of treatment, except that:

i. Speech therapy services rendered for treatment of delays in speech development, unless resulting from disease, injury or congenital defects are not covered;

22. Transportation services, limited to ambulance for medical emergency only;

23. Maternity and related newborn care;

24. Diabetic supplies and equipment;

25. Services for mental health or behavioral conditions;

i. Inpatient hospital services, including psychiatric hospitals, limited to 35 days per year;

ii. Outpatient benefits for short-term, outpatient evaluative and crisis intervention or home health mental health services, limited to 20 visits per year. When authorized by the Division of Medical Assistance and Health Services, inpatient benefit exchanges are allowed, as follows:

(1) One mental health inpatient day may be exchanged for up to four home health visits or four outpatient services, including partial care. This is limited to an exchange of up to a maximum of 10 inpatient days for a maximum of 40 additional outpatient visits.

(2) One mental health inpatient day may be exchanged for two days of treatment in partial hospitalization up to the maximum number of covered inpatient days.

iii. Inpatient and outpatient services for substance abuse are limited to detoxification; and

iv. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:77A) are not eligible for payment under NJ FamilyCare–Plan I; and

26. Elective/induced abortion services.

(b) Unless listed in (a) above, no other services shall be covered by NJ FamilyCare–Plan I. Services which shall not be covered include, but shall not be limited to:

1. Services that are not medically necessary;

2. Private duty nursing, unless prior authorized by the Division;

3. Intermediate care facilities for mental retardation (ICF/MR);

4. Personal care assistant services;

5. Medical day care services;

6. Chiropractic services;

7. Dental services;

8. Orthotic devices;

9. Targeted case management for the chronically ill;

10. Christian Science sanitaria care and services;

11. Durable medical equipment;

12. Routine transportation, including non-emergency ambulance, invalid coach and lower mode (car, taxi, bus) transportation;

13. Hearing aid services;

14. Blood and blood plasma, except that administration, processing of blood, processing fees and fees related to autologous blood donations shall be covered;

15. Cosmetic services;

16. Nursing facility (long term care) services;

17. Special and remedial educational services;

18. Experimental and investigational services;

19. Infertility services;

20. Medical supplies, except that diabetic supplies shall be a covered service;

21. Rehabilitative services for substance abuse (methadone maintenance is not covered);

22. Weight reduction programs or dietary supplements;

23. Acupuncture and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery;

24. Temporomandibular joint disorder (TMJ) treatment, including treatment performed by prosthesis placed directly in the teeth;

25. Recreational therapy;

26. Sleep therapy;

27. Court ordered services;

28. Thermograms and thermography;

29. Biofeedback;

30. Radial keratomy;

31. Respite care;

32. Custodial care;

33. EPSDT services; and

34. Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:77A).

Special New Rule, R.2003 d.98, effective January 31, 2003.
See: 35 N.J.R. 1303(a).
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
In (a)25, added iv; in (b), added 34.

SUBCHAPTER 6. AUTHORIZATIONS REQUIRED BY MEDICAID AND THE NJ FAMILYCARE PROGRAMS

10:49–6.1 Prior and retroactive authorization (general)

(a) Under the Programs, payment for certain services shall require prior authorization except in an emergency. It is the responsibility of the provider to obtain prior authorization before furnishing or rendering a service. Specific instructions are detailed in the appropriate Provider Services chapter.

1. Prior authorization should not be construed as a guarantee that a person is eligible for the New Jersey Medicaid or NJ FamilyCare program. At the time the service is to be provided, it is the provider's responsibility to verify eligibility.

2. "Medical emergency" means a critical illness or injury status for which prompt medical care may be crucial to saving life and limb or sparing the beneficiary significant or intractable pain. Services provided for a medical emergency are exempt from prior authorization. Any service classified as a medical emergency that would have been subject to prior authorization had it not been so classified, must be supported by a practitioner's statement which describes the nature of the emergency, including relevant clinical information, and must state why the emergency services rendered were considered to be immediately necessary. To simply state that an emergency did exist is not sufficient.

1. WFNJ/GA claims processed by the Division's fiscal agent are not subject to the fair hearing processes described at N.J.A.C. 10:49–9.14.

Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

10:49–24.3 Services available under the Work First New Jersey/ General Assistance (WFNJ/GA) program

(a) The Medicaid fiscal agent shall reimburse only those WFNJ/GA program covered services listed below in this subsection when provided in an ambulatory setting, except as specified in N.J.A.C. 10:49–24.4(a)14. These services include:

1. Abortion (elective/induced);

2. Acupuncture;

3. ADDP covered anti-retroviral drugs;

4. Ambulance;

5. Ambulatory surgery;

6. Blood and blood plasma;

7. Case management services for the chronically mentally ill (for specific information, see N.J.A.C. 10:73);

8. Certified nurse practitioner/clinical nurse specialist services (for specific information, see N.J.A.C. 10:58A);

9. Chiropractic services (for specific information, see N.J.A.C. 10:68);

10. Clinic services (services in an independent outpatient health care facility, ambulatory care facility, ambulatory surgical center, ambulatory care/family planning/surgical facility, drug treatment center, Federally qualified health center, free-standing end-stage renal dialysis facility), such as dental, family planning, laboratory, mental health, minor surgery, personal care assistance, podiatry, radiology, rehabilitation, or vision care (for specific information, see N.J.A.C. 10:66), except that:

i. Professional services provided by a residential alcohol or drug abuse treatment facility to an individual residing in the facility shall not be processed;

11. Dental services, including dentures (for specific information, see N.J.A.C. 10:56);

12. Durable medical equipment;

13. Family planning services, including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling, except that:

i. Services provided primarily for the diagnoses and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures shall not be processed.

14. Hearing aid services (for specific information, see N.J.A.C. 10:64);

15. Home care services, including home health care (for specific information, see N.J.A.C. 10:60);

16. Hospice services, except those provided in a nursing home facility (for specific information, see N.J.A.C. 10:53A);

i. The following hospice services, with corresponding HCPCS, shall be processed under the WFNJ/GA program:

(1) Y6333 Routine home care rate;

(2) Y6334 Continuous home care rate; and

(3) Y6343 Drugs and biologicals co-payment (rendered in places other than long term care facilities).

ii. The following hospice services, with corresponding HCPCS, shall not be processed under the WFNJ/GA program:

(1) Y6335 Inpatient respite care rate;

(2) Y6336 General inpatient care;

(3) Y6337 Therapeutic leave days;

(4) Y6338 Bed hold days;

(5) Y6339 Hospice Respite Care; and

(6) Z2015 Room and board;

17. Laboratory (clinical) services (for specific information, see N.J.A.C. 10:61);

18. Medical supplies and equipment (for specific information, see N.J.A.C. 10:59);

19. Mental health services (for specific information, see N.J.A.C. 10:66);

20. Non-maternity nurse-midwifery services, such as family planning (for specific information, see N.J.A.C. 10:58);

21. Optometric services (for specific information, see N.J.A.C. 10:62);

22. Optical appliances (for specific information, see N.J.A.C. 10:62);

23. Personal care assistant;

24. Thermograms;

25. Thermography;

26. Pharmaceutical services (for specific information, see N.J.A.C. 10:51);

i. Prior authorization shall be required where patterns of medically harmful or inappropriate use of specific drugs, therapeutic drug classes, enteral nutritional supplements, needles and syringes have been identified, or for claims originating in certain municipalities where such patterns have been identified; and

ii. Effective with claims for dates of service on or after August 7, 2000, the Division's processing of claims for certain antiretroviral drugs shall be accomplished under the AIDS Drug Distribution Program (ADDP), administered by the Department of Health and Senior Services (DHSS), except for emergency supplies as authorized under WFNJ/GA to avert a lapse in treatment. These drugs shall include, but may not be limited to: thymidine nucleosides, thymidine analogs, protease inhibitors, nucleoside analog reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, carbocyclic nucleoside analogs, purine nucleoside analogs of deoxyadenosine, and primidine nucleoside analogs;

27. Physician services (for specific information, see N.J.A.C. 10:54);

28. Podiatric services (for specific information, see N.J.A.C. 10:57);

29. Prosthetic and orthotic devices (for specific information, see N.J.A.C. 10:55);

30. Psychological service (for specific information, see N.J.A.C. 10:67);

31. Radiological services (for specific information, see N.J.A.C. 10:54);

32. Rehabilitative services (for specific information, see N.J.A.C. 10:66). Payments shall be made to eligible Medicaid providers only. No payment shall be made to privately practicing therapists who are not Medicaid providers. Rehabilitative services include:

i. Physical therapy;

ii. Occupational therapy;

iii. Speech-language pathology services; and

iv. Audiology services;

33. Transportation services which include ambulance and mobility assistance vehicle (for specific information, see N.J.A.C. 10:50 and 10:66);

34. Medicare coinsurance and/or deductible for services specified in (a)1 through 23 above, if otherwise reimbursed by the New Jersey Medicaid program; and

35. Inpatient services provided by Mt. Carmel Guild Hospital located in Newark, New Jersey.

(b) Adult mental health rehabilitation services provided in/by community residence programs (see N.J.A.C. 10:77A) shall not be eligible for reimbursement by DMAHS, but may be eligible for reimbursement by the Division of Mental Health Services (DMHS).

Special amendment, R.2002 d.214, effective June 10, 2002.
See: 34 N.J.R. 2338(a).
Rewrote the section.
Amended by R.2004 d.8, effective January 5, 2004.
See: 35 N.J.R. 2620(a), 35 N.J.R. 4204(a), 36 N.J.R. 189(a).
Added (b).

10:49–24.4 Services that shall not be processed by the fiscal agent

(a) Consistent with N.J.A.C. 10:90–13.1(a)2, the following services shall not be processed by the fiscal agent:

1. Case management for early intervention services;

2. Early and periodic screening, diagnosis, and treatment (EPSDT) screenings, and any other EPSDT services needed to ameliorate a defect if the services are otherwise not covered by the WFNJ/GA program;

3. EPSDT school-based or early intervention rehabilitation services;

4. Federally qualified health center encounter rates;

5. For individuals dually eligible for Medicaid and WFNJ/GA, any services that should have been, but were not, covered by an HMO to which the Medicaid program has made a payment, shall be provided or covered as a medical service;

6. HealthStart maternity and pediatric care services;

7. Inpatient or outpatient services/care provided by an enrolled hospital provider, either in-State or out-of-State, including, but not limited to, psychiatric hospitals, acute care hospitals, special hospitals, rehabilitation hospitals, non-religious medical institutions and county or State hospitals, except that:

i. Inpatient services provided by Mt. Carmel Guild Hospital located in Newark, New Jersey shall be processed by the fiscal agent; and

ii. Services provided by a hospital when that facility is not providing them as hospital services and is not enrolled as a hospital, including, but not limited to, hospital-based home health agency services, dental clinic services, end-stage renal dialysis services, hospital-based transportation services, and case management services for the chronically mentally ill, shall be processed;

8. Intermediate care facility for the mentally retarded (ICF/MR) services;

9. Managed care services;

10. Maternity services, including prenatal, delivery and postpartum services (through two months), provided by any type provider, including, but not limited to, physicians, certified nurse specialists/clinical nurse practitioners, certified nurse-midwives and clinics;

11. Nursing facility per diems;

12. Medical day care services;

13. Methadone maintenance services, identified by HCPCS Z2006, as set forth at N.J.A.C. 10:66–6.3(m);

14. Physician, clinical laboratory, or other professional medical services provided while a WFNJ/GA eligible individual is a patient in a hospital, including an acute care hospital, special hospital, rehabilitation hospital, non-religious medical institution, ICF/MR, an inpatient psychiatric hospital, an inpatient psychiatric program for children under the age of 21 (residential treatment centers) or services provided to a WFNJ/GA eligible individual while in an outpatient hospital department or a hospital emergency room;

15. Professional services rendered to beneficiaries residing in a residential treatment facility for drug or alcohol abuse;

16. Services provided under a home and community based services waiver under section 1915(c) of the Social Security Act, 42 U.S.C. § 1396;

17. Services that would otherwise be covered under other health insurance coverage, including services that should have been, but were not, provided by an HMO that the WFNJ/GA eligible individual is enrolled in; and

18. Transportation services provided under contract with a vendor or through a contract with the county board of social services.

10:49–24.5 Basis for reimbursement

Except as noted under N.J.A.C. 10:49–24.3(a)16ii, payment for services shall be based upon the Medicaid reimbursement methodology for the respective service. (See specific provider chapter(s) for reimbursement methodology and requirements.)

APPENDIX

STATE OF NEW JERSEY
DEPARTMENT OF
HUMAN SERVICES
DIVISION OF
MEDICAL ASSISTANCE
AND
HEALTH SERVICES

MEDICAID ELIGIBILITY IDENTIFICATION CARD 1939902

ADDITIONAL HEALTH INSURANCE*

HSP (MEDICAID) CASE NO. PERSON NO.

VALID FROM TO

SOC. SEC. ACCT. NO. DATE OF BIRTH

USE THIS CARD WHEN YOU NEED MEDICAL SERVICES

RECIPIENT'S SIGNATURE

FD-73/178 (REV. 3/91)

IMPORTANT NOTICE

You must sign the front of this card on the line above the Recipient's Signature. If you are unable to sign the card, the individual representing you must sign your name, initial the card and explain his/her relationship to you.

Immediately notify the Medicaid District Office or the Division of Youth and Family Services case manager or the County Welfare Agency (as appropriate):

1. If you have Medicare coverage or other health insurance not listed or incorrectly listed; or
2. If any changes are necessary to the front of this card; or
3. If you have any questions regarding the use of this card; or
4. If this card is lost or stolen. (Unless the report of the loss or theft can be documented at the appropriate agency, you may be liable to repay Medicaid for any benefits obtained through its unauthorized use).

FEDERAL and STATE LAW make it a crime and set the punishment for persons who have been found guilty of making any false statement or representation of a material fact to receive any benefit or payment under the Medicaid Program. The Department of Human Services is required to make you aware of this law and to warn you against making any false statement in an application or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended.

THIS CARD IS NON-TRANSFERABLE UNDER PENALTY OF LAW.
NOTICE TO PROVIDERS

The printed name which appears directly above the line for Recipient's Signature on this card is the MEDICAID eligible person. This name identifies that person ONLY (except AFDC can include spouse/child(ren) listed with PERSON NUMBERS) as being eligible for MEDICAID benefits within the time period shown. If the name of a "REPRESENTATIVE PAYEE" appears on this card, that individual is not eligible for Medicaid benefits.

* Ask the cardholder if there is Medicare coverage or other health insurance not listed. Please indicate this information in the appropriate area on the claim form. Prior to billing Medicaid you are to bill other third party payers in accordance with N.J.A.C. 10:49.

Form #1

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

MEDICALLY NEEDY CLAIM TRANSMITTAL

RECIPIENT INFORMATION

HSP (Medicaid) CASE NO.

NAME

ADDRESS

PROVIDER INFORMATION

PROVIDER NO.

PROVIDER NAME

PROVIDER ADDRESS

TYPE OF SERVICE	DATE OF SERVICE	CHARGE	PAYMENT FROM OTHER SOURCE	CLIENT OBLIGATION	TOTAL FROM OTHER SOURCES
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Provider Instructions and Information:

- The services listed above were provided to the identified individual during a covered retroactive period.
- This transmittal does not guarantee payment. Your claim will be processed in accordance with current Medicaid and Medically Needy regulations.
- Each claim form submitted for payment for services listed above must be attached to this document.
- Please enter your provider number in the appropriate space in the upper right corner.
- Any amount listed in the column entitled "Client Obligation" is the responsibility of the client and should be paid by the client directly to you.

NUMBER OF ITEMS _____

SIGNATURE _____
Authorized Representative

FD-311 (5/86)

Form #2

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PUBLIC ASSISTANCE INQUIRY

Referral for: ☐ SSI ☐ New Jersey Care ☐ Medicaid Only ☐ AFDC ☐ Newborn (complete items 1,2,4,11a,15 only)

TO: FROM:

(SSA : DO)
_____ (County Welfare Agency) _____ Hospital

_____

Date _____

_____ ☐ M Sex ☐ F

1 Name: _____ (Last) (First) (Middle)
(For newborn referral, enter name and sex of parent.)

2. Social Security Account Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

3 Permanent Home Address. _____ Telephone. _____

4 Marital Status: *(Check one)* Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Unknown ☐

5. Date of Admission: _____ Date of Birth: _____

6 Address From Which Admitted: _____ Telephone: _____

7 Diagnosis _____

8 Prognosis: _____
(For SSI disability, blindness and AFDC incapacity)

9. Referring Physician: _____ Telephone: _____

10. Spouse: Name: _____ Age. _____ Telephone. _____

Address: _____

11 Minor Children *(First Names and Ages)*: _____

(a) Newborn Data. Name _____ Date of Birth: _____ ☐ M Sex ☐ F

Mother's HSP (Medicaid) Case No.: ___ ___ ___ ___ ___ ___ ___ ___ ___ – ___ ___

12 Next of Kin *(If other than Spouse or Children)* _____

Address: _____ Telephone. _____

13 Gross Monthly Income of Patient: _____ Source: _____

14. Gross Monthly Income of Family Members: _____

15. Hospital Insurance: Blue Cross ☐ I.D. No.: _____ Medicare ☐ H.I.C. No.: _____

(a) Applicable to Newborn? Yes ☐ No ☐

Other ☐ Carrier Name: _____ Policy No.: _____

16. Employer's Name. _____ Address: _____

17. Name of Spouse's Employer. _____ Address: _____

PA II (rev. 7-89)

Form #3

18. What inquiries have been made regarding financial responsibility for the hospital bill?

What were the results? _____

19. Does patient, patient's authorized agent, or relatives know that an inquiry is being made for the previously checked program?

Yes ☐ No ☐

20. Whereabouts

Is client still in hospital? Yes ☐ No ☐

If YES, anticipated address upon discharge: _____

If NO, date of discharge: _____

Present address if known: _____

21. Other Comments: _____

22. The above patient is being cared for in the hospital since _____ (Date) on a ward service or general service basis as to professional and other personal services and I believe that such a patient may be eligible for the previously checked program.

Signature _____ Title: _____ Date: _____

23. Signature of Patient or Relative: _____ Date: _____

PLEASE READ CAREFULLY BEFORE SIGNING

I understand that I must furnish certain information to the SSA DO or the County Welfare Agency to establish eligibility and extent of need for Supplemental Security Income Benefits or public assistance, and that the appropriate agency will help to secure this information and verify it. I will supply complete and accurate information, within my knowledge, to representatives of the SSA DO or the County Welfare Agency. I hereby authorize and direct my relatives, physician, hospital, employers, bankers, and any other person having information concerning the persons named above to furnish complete details to the appropriate agency investigating my application for such assistance. I understand that the information obtained will be used only in connection with the application for or receipt of assistance.

"I further authorize the Social Security Administration to release benefit information and entitlement dates to the hospital whose name appears on the reverse of this form. I understand the hospital will only use this information for purposes of establishing my eligibility to Medicaid."

Signature: _____ Relationship: _____ Date: _____

IF NOT SIGNED BY PATIENT, EXPLAIN WHY: _____

NOTICE TO THE SSA DO OR CWA INITIALLY RECEIVING THIS INQUIRY. WHEN IT IS NECESSARY TO REFER THE APPLICANT TO ANOTHER PUBLIC ASSISTANCE AGENCY, INCLUDE AT LEAST A COPY OF THIS PA-1C FORM.

DMAHS USE ONLY

PROVIDER USE ONLY

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

CERTIFICATION OF PRESUMPTIVE ELIGIBILITY

CLIENT INFORMATION:

Name: _____ County of Residence _____

Address: _____ Birth Date: _____

_____ Social Security No. _____

Telephone No.: ( ) _____ Household Unit: _____ *(No. of persons in household)*

(Check appropriate boxes below.)

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race: ☐ White ☐ Black ☐ American Indian ☐ Oriental ☐ Hispanic ☐ Other

Does client have a pending AFDC, SSI, Medicaid application? ☐ Yes ☐ No *(If yes, circle program.)*

Client is: ☐ U.S. Citizen ☐ Alien admitted for permanent residence
☐ Alien admitted for temporary residence ☐ Undocumented alien

Medicare Coverage: ☐ Yes ☐ No If Yes, HIC Number: _____

Other Insurance Company: _____ Other Insurance Policy No.: _____

INCOME INFORMATION:

Total Household Income:	**Income**	**Frequency**	**Gross Monthly Amt.**	**Source**
Gross Earnings				
Gross Earnings				
Gross Unearned Amount				
Gross Unearned Amount				
Gross Unearned Amount				
Gross Child Support Amount				
Gross Alimony Amount				

Total Monthly Gross Income $ _____

Child Care Expense Amount: _____ Weekly _____ BiWeekly _____ Monthly

PREGNANCY INFORMATION:

Date of L.M.P. _____ Pregnancy Due Date: _____

CERTIFICATION STATEMENT:

I, _____ attest that I have read and agree to the above statements and fully realize that the county welfare agency relies upon the truth and accuracy of my statements. I have received a copy and understand the Patient Guidelines.

_____ _____
Applicant Signature *Date*

I certify the above applicant is pregnant and presumptively eligible for limited Medicaid benefits in accordance with N.J.A.C. 10:72-6.1 et seq.

_____ _____ _____
Provider Agency Name *Address* *Telephone*

_____ _____
Provider Signature *Date*

IMPORTANT: THE ORIGINAL FORM MUST BE FORWARDED TO THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, ISS SECTION, AREA #3, PRESUMPTIVE ELIGIBILITY RECORDS, CN-712, TRENTON, NJ 08625, WITHIN TWO (2) DAYS OF COMPLETION.

Form #4 FD 334

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

APPLICATION FOR PAYMENT OF UNPAID MEDICAL BILLS
NEW JERSEY HEALTH SERVICES PROGRAM (MEDICAID)

NOTE: THIS FORM (FD-74) IS GIVEN ONLY TO APPLICANTS WHO INDICATE THEY HAVE UNPAID BILLS FOR MEDICAL SERVICES RECEIVED DURING THE THREE (3) MONTHS PRIOR TO APPLICATION FOR PUBLIC ASSISTANCE OR SUPPLEMENTAL SECURITY INCOME. THE FD-74 MUST BE SUBMITTED WITHIN SIX (6) MONTHS FROM THE DATE OF APPLICATION FOR PUBLIC ASSISTANCE OR SUPPLEMENTAL SECURITY INCOME.

The New Jersey Medicaid Program will evaluate this application to determine whether or not payment can be made by the program for covered Medicaid services received by the applicant and or eligible person(s) living in the same household during the specified period. **This refers only to those services for which bills remain unpaid. The Medicaid Program will not consider payment of bills that have already been paid.**

PART I - APPLICANT INFORMATION

1. _____ 2. _____ 3. _____
Name of Applicant *Applicant's HSP (Medicaid) Case No.* *Applicant's Birthdate*

4. _____ _____ _____ _____
Street Address - Apartment Number *City* *State* *Zip*

_____ _____ _____
Telephone Number (area code) *Social Security Account Number* *County of Residence*

5. _____ 6. _____
Date of Application for Public Assistance or Supplemental Security Income *Name and address of Agency processing application for Public Assistance or Supplemental Security Income (i.e., County Welfare Agency or Social Security Office, etc.)*

7. If the applicant has applied for Aid to Families with Dependent Children (AFDC) or Assistance to Families of the Working Poor (AFWP), list the full names, ages and relationship of each dependent child or eligible person(s) living with applicant.

_____

_____

_____

PART II - MEDICAL INFORMATION

A. PLEASE COMPLETE ALL QUESTIONS LISTED ON REVERSE SIDE AS ACCURATELY AS POSSIBLE.
B. YOU MUST ATTACH COPIES OF ALL UNPAID MEDICAL BILLS TO THIS APPLICATION.

8. List all unpaid medical bills and the dates incurred during the three (3) months before application for assistance.

Type of Services (Hospital, Physician, Etc.) Name of Hospital, Physician Etc.	Patient	Date(s) of Service	Total Amount Due

SEE OTHER SIDE

FD-74 Form #5

PART III - FINANCIAL INFORMATION

9 Are any of the medical bills listed on this application the result of a job related injury, auto or other accident? Yes ( ) No ( )
If yes, explain and indicate the name of the insurance company and your legal representative.

10 What were your income and resources at the time the medical bills were incurred for the **three month period before your application for Public Assistance or Supplemental Security Income?** If you had no income or resources during the three (3) months prior, please specify in the spaces provided. If you were under 18 years old, you must indicate your parent's income and resources.

Please check below the type of income you received and in which month(s) received. Also, please submit verification of your income (copies of checks, pay stubs, etc.) with your application.

		TOTAL MONTHLY AMOUNT RECEIVED
_____ EMPLOYMENT	WHEN RECEIVED:	
_____ UNEMPLOYMENT	_____ 1st MONTH BEFORE APPLICATION	$
_____ DISABILITY	_____ 2nd MONTH BEFORE APPLICATION	$
_____ SOCIAL SECURITY	_____ 3rd MONTH BEFORE APPLICATION	$
_____ ALIMONY		
_____ CHILD SUPPORT	**HOW OFTEN RECEIVED:**	
_____ OTHER:	_____ WEEKLY _____ BI-WEEKLY _____ MONTHLY	

_____ NO INCOME RECEIVED DURING THE THREE MONTHS BEFORE APPLYING FOR PUBLIC ASSISTANCE OR SUPPLEMENTAL SECURITY INCOME

What resources did you have during this same time period?

_____ CHECKING ACCOUNT $ _____ _____ STOCKS, BONDS, ETC. $ _____
_____ SAVINGS ACCOUNT $ _____ _____ SPECIFY: _____
_____ AUTOMOBILE: 1. Year 19 ___ make _____ _____ OTHER: _____
2. Year 19 ___ make _____
_____ INSURANCE POLICY 1. Face Value $ _____ Cash Value $ _____
2. Face Value $ _____ Cash Value $ _____
_____ NO RESOURCE OF ANY KIND

11 Did you have any type of Medical or Health Insurance coverage, such as Blue Cross or Medicare? Yes ( ) No ( )
(If yes, explain below.)

NAME OF INSURANCE COMPANY OR PROGRAM	POLICY NUMBER OR MEDICARE NUMBER	NAME OF INSURED

12. I certify that the above information is true and correct to the best of my knowledge and that no facts have knowingly been omitted. I understand that my application may be investigated and I agree to cooperate in such an investigation. I further understand that the law provides for fine or imprisonment, or both, for a person hiding facts or not telling the truth.

Signature of Applicant *Relationship to Applicant* *Date*

NOTE. This application must be signed by the applicant, or relative, or legal guardian or friend acting on behalf of the applicant. ***This application must not be signed by the applicant's physician or anyone representing a hospital or collection agency.***

MAIL THIS COMPLETED APPLICATION, TOGETHER WITH COPIES OF ALL UNPAID MEDICAL BILLS, TO THE RETRO-ACTIVE ELIGIBILITY UNIT, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, CN-712-10, TRENTON, NJ 08625.

DEPARTMENT OF HUMAN SERVICES
MEDICAID-ID

7841006

VALID ONLY FOR THE MONTH OF
MEDICAID HSP #

ELIGIBLE PERSONS	PER #	ELIGIBLE PERSONS	PER #
1		11	
2		12	
3		13	
4		14	
5		15	
6		16	
7		17	
8		18	
9		19	
10		20	

V O I D

NOTICE TO PROVIDER

REQUEST PERSONAL IDENTIFICATION IF YOU DO NOT KNOW THE PATIENT

PLEASE REPORT THE CASE NAME, CASE NUMBER, AND PERSON NUMBER ACCURATELY ON ALL CLAIM FORMS AND OTHER COMMUNICATIONS RELATING TO THE CLAIM

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES
MEDICAID ELIGIBILITY IDENTIFICATION

CARRY THIS CARD AT ALL TIMES

Present it to the pharmacy, hospital, physician or other providers for medical services rendered in behalf of eligible persons.

RECIPIENT'S SIGNATURE REQUIRED

No es valida si no está firmada. Entréguela a la farmacia, hospital, médico u otros proveedores de servicios médicos prestados a personas que reunen las condiciones necesarias para poder usar Medicaid.

NOTICE

Federal law makes it a crime and sets punishment for persons who have been found guilty of making any false statement or representation of a material fact to receive any benefit or payment under the medical assistance program. This Department is required to make you aware of this law and to warn you against making any false statement in an application or in a fact used in determining the right to a benefit or converting a benefit to the use of any person other than one for whom it was intended.

NON-TRANSFERABLE UNDER PENALTY OF LAW

AVISO

De acuerdo con la ley federal es un delito hacer una declaración falsa a fin de recibir un beneficio o pago bajo el programa de asistencia médica, y dicha ley fija pena a las personas que la infrinjan. Este Departamento le tiene que informar de dicha ley y le tiene que advertir que no haga ninguna falsa declaración en una solicitud para determinar su derecho a un beneficio, o para convertir el beneficio al uso de otra persona que no sea la destinada a recibir el mismo.

INTRANSFERIBLE BAJO PENA DE LA LEY

Form #6

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

VALIDATION OF ELIGIBILITY

Last Name	First Name	Mi	Health Services Program Case No.	Person Number

NOTICE TO PROVIDERS

This form identifies the person listed above as eligible for authorized services under the New Jersey Health Services Program (Medicaid).

This form also serves as a validation of eligibility for up to 31 days from date of issue. All policies and procedures specified in the appropriate New Jersey Health Services Program Provider Manual are to be followed by providers when rendering services to this person.

The signature, title and telephone number of an authorized representative of the State Institution listed below must be included to validate this form.

THIS FORM IS THE PROPERTY OF THE STATE OF NEW JERSEY AND MUST BE RETURNED WITH THE PATIENT.

Signature and Title of State Institution Representative	Date of Issue
Name of State Institution	Telephone No.

FD-34 (rev. 5/83)

Form #7

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

PROVIDER APPLICATION

1 _____ 2 _____
Legal Name of Provider — Type of Business or Facility

_____
Business Name if Different From Above

3 _____
Address (Service Location Only) Street — City — County — State — Zip Code

4 _____ 5 _____ 6 _____
Employer ID Number — Telephone Number — Length of time at above address

7 _____ 8 _____
Billing Address if different — Name of Administrator, Chief Executive Officer or other responsible official

_____

9 Indicate legal status of your organization: Profit _____, Non-Profit _____, Private _____, Public _____, Municipal _____, State _____, Charity _____, School Nurse _____, County _____, Other _____ If other, please specify _____

10 List the specific service(s) for which you are requesting approval for reimbursement under the Medicaid Program

_____

11 Do you operate from more than one location? _____ Yes _____ No If yes, list all other subsidiary or affiliated organizations below (Name and service address)

1 _____ _____
2 _____ _____
3 _____ _____
Please attach additional sheet if necessary

12 Please indicate if you are a member of a chain organization _____ Yes _____ No. If yes, indicate name _____

13 Please indicate your preference to receive central or local reimbursement

_____ to each satellite location;
_____ to central location at _____

Billing through a central location is allowable and left to the provider's discretion. However, if the provider chooses to bill centrally, pre-addressed claims MUST be utilized since they reflect the proper address and provider number for that location

14 Do you require a Certificate of Need under the Health Facilities Planning Act from the New Jersey Department of Health? _____ Yes _____ No If yes, attach a copy of the Certificate of Need If no, explain why you do not require a certificate

15 If your business or facility requires a license permit, indicate type _____ and number _____ Please attach a copy of the license permit, i.e., Independent Laboratory Certification.

16 CERTIFICATION, ACCREDITATION OR APPROVAL Specify type and attach copy For example JCAHO (hospitals), New Jersey Department of Health (clinics), Division of Mental Health and Hospitals (mental health clinics), State Board of Dentistry (dental clinics), State Board of Pharmacy (providers offering pharmaceutical services), American Board for Certification in Prosthetics and Orthotics (Prosthetist and or Orthotist) See Item 16.

17 Approved by Medicare? _____ Yes _____ No If yes, please indicate Medicare provider number _____ and attach copy of your Medicare approval

18 Are you currently or have you ever been an approved provider of services under the New Jersey Medicaid Program or the Medicaid Program of any other state or jurisdiction? _____ Yes _____ No If Yes, list types of services provided and current status If you were approved at one time and you no longer participate, explain the reason(s)

FD-20(12/90)

Form #8

19 Have any of the entities named in response to questions 1. or 11 or their officers or partners, or any of the individuals named in response to questions 8 ever been the subject of any license suspension, revocation, or other adverse licensure action in this state or any other jurisdiction? _____ Yes _____ No If yes, please explain

20 Have any of the entities named in response to question 1 or 11 or their officers or partners, or any of the individuals named in response to questions 8 ever been indicted, charged, convicted of, or pled guilty or no contest to any federal or state crime in this state or any other jurisdiction? _____ Yes _____ No If yes, please explain

21 Have any of the entities named in response to questions 1 or 11 or their officers or partners, or any of the individuals named in response to questions 8 ever been the subject of any Medicaid (Title XIX) or Medicare (Title XVIII) suspension debarment disqualification or recovery action in this state or any other jurisdiction? _____ Yes _____ No If yes please explain _____

22 Do any of the entities named in response to question 1 or 11 or their officers or partners, or any of the other individuals named in response to questions 8 own or have any financial interest in any other provider participating in the New Jersey Medicaid (Title XIX) Program or the Medicaid (Title XIX) Progam of any other state or jurisdiction? _____ Yes _____ No If yes please list provider name and nature of relationship.

23 Do you charge for goods and or services? TO ALL _____ . TO NONE _____ . TO CERTAIN GROUPS ONLY _____
If you charge to all or only certain groups, please explain your arrangement and attach a copy of your fee schedule

24 List days and hours of operation

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

NEW JERSEY HEALTH SERVICES PROGRAM
TITLE XIX (MEDICAID)

PROVIDER AGREEMENT
BETWEEN
NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND

_____
PROVIDER

PROVIDER AGREES:

1. To comply with all applicable State and Federal Medicaid laws and policy, and rules and regulations promulgated pursuant thereto:

2. To keep such records as are necessary to fully disclose the extent of services provided to individuals receiving assistance under the Medicaid Program;

3. To furnish the Division of Medical Assistance and Health Services, the Secretary of Health and Human Services and the Medicaid Fraud Section, Division of Criminal Justice with such information as may be requested from time to time, regarding any payments claimed for providing services under the Medicaid Program;

4. To comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and Section 1909 of P.L. 92-603, Section 242 (c) which makes it a crime and sets the punishment for persons who have been found guilty of making any false statement or representation of a material fact in order to receive any benefit or payment under the Medical Assistance Program. (The Department of Human Services is required by Federal regulation to make this law known and to warn against false statements in an application/agreement or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended).

5. To comply with the disclosure requirements specified in 42 CFR 455.100 through 42 CFR 455.106.

The provider may, on thirty days written notice to the Division, terminate this Agreement.

_____ _____
DATE SIGNATURE OF PROVIDER

_____
TITLE

FD-62 (rev. 6/86) Medicaid 3031-M Ed. 6/86

Form #9

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0086

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

(a). Name of Entity	D/B/A	Provider No	Vendor No.	Telephone No.

Street Address	City, County, State	Zip Code

(b) *(To be completed by HCFA Regional Office)* Chain Affiliate No. ☐☐☐☐☐ LB1

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

☐ Yes ☐ No LB2

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

☐ Yes ☐ No LB3

C Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

☐ Yes ☐ No LB4

III (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks

Name	Address	EIN
		LB5

(b) Type of Entity ☐ Sole Proprietorship ☐ Partnership ☐ Corporation LB6
☐ Unincorporated Associations ☐ Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks

Check appropriate box for each of the following questions

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers

☐ Yes ☐ No LB7

Name	Address	Provider Number

Form HCFA-1513

Form #10

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0086

IV (a) Has there been a change in ownership or control within the last year?
If yes, give date ☐ Yes ☐ No LB8

(b) Do you anticipate any change of ownership or control within the year?
If yes, when? ☐ Yes ☐ No LB9

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? ☐ Yes ☐ No LB10

V Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations ☐ Yes ☐ No LB11

VI Has there been a change in Administrator, Director of Nursing or Medical Director within the last year? ☐ Yes ☐ No LB12

VII (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)
Name EIN # ☐ Yes ☐ No LB13

Address

LB14

VII (b) If the answer to Question VII a. is No, was the facility ever affiliated with a chain?
(If YES, list Name, Address of Corporation and EIN)
Name EIN # ☐ Yes ☐ No LB18

Address

LB19

VIII Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years? ☐ Yes ☐ No LB15

If yes, give year of change _____
Current beds _____ LB16 Prior beds _____ LB17

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE

Name of Authorized Representative (Typed)	Title
Signature	Date

Remarks

Form HCFA-1513

PATIENT CERTIFICATION FORM

PATIENT'S NAME ______________________

HIC NO. ______________________ HSP NO. ______________________

MEDICARE PATIENT'S AUTHORIZATION	MEDICAID PAYMENTS
I authorize any holder of medical or other information about me to release to the Social Security Administration, or the Health Care Financing Administration or its intermediaries or carriers, any information needed for this or a related claim. I certify that the service(s) covered by this claim has been received and request payment in accordance with Program Policy either to Dr. ________ or myself if the doctor does not accept assignment.	Authorization to Release Information and Payment Request. I certify that the service(s) covered by this claim has been received and request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the State Agency or its authorized Agents any information needed for this or a related claim.

Patient or Authorized Representative's Signature	Date of Service	Control Number	Other Comments

THIS FORM TO BE RETAINED IN PROVIDER'S OFFICE
THIS FORM HAS BEEN APPROVED BY
THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES,
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
FOR USE IN THE MEDICAID PROGRAM

7445-M Ed. 7/82

FD-197-N.J. (rev. 7/82

Form #11

Notice to All Applicants and Providers

Please note that the ownership and direction of a professional practice must be in compliance with all applicable State statutes and regulations governing licensure.

Any individual or entity found by staff of the Division of Medical Assistance and Health Services to be in violation any State statute or regulation governing the ownership and direction of a professional practice will be subject to appropriate sanctions contained in the statutes and regulations governing the programs administered by the Division of Medical Assistance and Health Services, including exclusion from the New Jersey Medicaid and NJ KidCare programs. In addition, such violations will be referred to the appropriate professional board or other licensure authority.

To be completed by owner, managing partner or chief executive officer:

I hereby certify that ______ (name of entity applying for program participation) is in compliance with State statutes and regulations governing the ownership and direction of a professional practice.

______________________ Date

______________________ Print or type name and title

______________________ Signature

Form #12

MEDICAL ASSISTANCE CUSTOMER CENTER
(MACC)

MACC OFFICE	DIRECTOR & PHONE #	ADDRESS
(03) BURLINGTON	Nancy Weber, Director	Mt. Laurel Corporate Park

MACC	OFFICE	DIRECTOR & PHONE #	ADDRESS
(11)	MERCER	(856) 787–3855 FAX#(856) 787–3877	1000 Howard Blvd, Suite 303 Mt. Laurel, NJ 08054–2355
(04) (08) (17)	CAMDEN GLOUCESTER SALEM	Eileen Calabro, Director (856) 614–2870 FAX#(856) 614–2575	1 Port Center, Suite 401 2 Riverside Dr. Camden, NJ 08103–1018
(06) (01) (05)	CUMBERLAND ATLANTIC CAPE MAY	, [Barbara Smith] Director (856) 690–5208 FAX#(856) 690–5223	Giles Building 1676 East Landis Ave PO Box 1513 Vineland, NJ 08362–1513
(07)	ESSEX	Kate Buckley–Straussl, Director (973) 648–3700 FAX#(973) 642–6468 John Russell, Northern Regional Administrator	153 Halsey St 4th Floor Newark, NJ 07101–8004
(09)	HUDSON	Robert Dueben, Director (201) 217–7100 FAX#(201) 217–7122	438 Summit Ave 6th Floor Jersey City, NJ 07306–3186
(12) (20)	MIDDLESEX UNION	, [Susan Simon] Director (732) 499–5700 FAX#(732) 499–5803	301 Blair Road 2nd Floor Avenel, NJ 07001–2936
(13)	MONMOUTH	, [Carol Coyle] Director (732) 761–3600 FAX#(732) 761–3621 or 3623 Thomas Rafferty, Southern Regional Administrator	Juniper Business Plaza 3499 Highway 9 North Suite 1H–A Freehold, NJ 07728–3287
(14) (10) (18) (19) (21)	MORRIS HUNTERDON SOMERSET SUSSEX WARREN	Stewart Klaus, Director (973) 631–6440 FAX#(973) 631–6448	10 Park Place Suite 340 Morristown, NJ 07960–7101
(15)	OCEAN	Gail Dempsey, Director (732) 255–0731 FAX#(732) 255–0743	1510 Hooper Ave Suite 130 Toms River, NJ 08753–2295
(16) (02)	PASSAIC BERGEN	Kathleen Lohrey, Director (973) 977–4077 FAX#(973) 684–8182	66 Hamilton St Paterson, NJ 07505–2021

Form #14

COUNTY BOARDS OF SOCIAL SERVICES

ATLANTIC 8:30–4:30	1	FORREST GILMORE, ACT. DEPT. HEAD KAREN B. ENOUS, DIRECTOR OF WELFARE & COMMUNITY DEVELOPMENT FAX 609–343–2374	ATLANTIC COUNTY DEPARTMENT OF FAMILY 1333 ATLANTIC AVE. ATLANTIC CITY, NJ 08401–8297	609–348–3001
BERGEN 8:00–4:30 8:00–8:00 (Tuesday)	2	EDWARD TESTA, DIRECTOR FAX 201–368–8710	BERGEN COUNTY BOARD OF SOCIAL SERVICES 216 ROUTE 17 NORTH ROCHELLE PARK, NJ 07662–3300	201–368–4200
BURLINGTON 8:00–5:00 8:00–7:30 (Thursday)	3	ANN SABOE, DIRECTOR FAX 609–261–0463	BURLINGTON COUNTY BOARD OF SOCIAL SERVICES HUMAN SERVICES FACILITY 795 WOODLANE RD. MOUNT HOLLY, NJ 08060–3335	609–261–1000
CAMDEN 8:30–4:30 7:30–7:30 (Thursday)	4	ROBERT ELLIS, DIRECTOR FAX 856–225–5145 (Director Only) FAX 856–225–7797	CAMDEN COUNTY BOARD OF SOCIAL SERVICES ALETHA R. WRIGHT ADMINISTRATION BLDG. 600 MARKET ST. CAMDEN, NJ 08102–8800	856–225–8800
CAPE MAY 8:30–4:30	5	JOSEPH B. FAHY, DIRECTOR FAX 609–889–9332	CAPE MAY COUNTY BOARD OF SOCIAL SERVICES SOCIAL SERVICES BLDG. 4005 ROUTE 9 SOUTH RIO GRANDE, NJ 08242–1911	609–886–6200
CUMBERLAND 8:30–4:30	6	GREGORY CURLISS, DIRECTOR FAX 856–692–7635	CUMBERLAND COUNTY BOARD OF SOCIAL SERVICES 13 NORTHEAST BLVD. VINELAND, NJ 08360	856–691–4600
ESSEX 8:00–5:30	7	JAMES J. WILLIAMS, DIRECTOR FAX 973–643–3985	ESSEX COUNTY DEPARTMENT OF CITIZEN SERVICES DIVISION OF WELFARE 18 RECTOR ST., 9TH FL. NEWARK, NJ 07102	973–733–3000
GLOUCESTER 7:30–4:30	8	CAROL PIRROTTA, DIRECTOR FAX 856–582–6587	GLOUCESTER COUNTY BOARD OF SOCIAL SERVICES 400 HOLLYDELL DR. SEWELL, NJ 08080	856–582–9200
HUDSON 8:00–5:00	9	ANGELICA HARRISON, DIRECTOR FAX 201–420–0343	HUDSON COUNTY DIVISION OF SOCIAL SERVICES JOHN F. KENNEDY OFFICE BLDG. 100 NEWKIRK ST. JERSEY CITY, NJ 07306	201–420–3000
HUNTERDON	10	JOHN F. CAHALAN, DIRECTOR	COUNTY OF HUNTERDON DIVISION OF SOCIAL SERVICES DEPARTMENT OF HUMAN SERVICES P.O. BOX 2900	

8:30–4:30		FAX 908–806–4588	FLEMINGTON, NJ 08822–2900	908–788–1300
MERCER 8:30–4:30 8:30–8:30 (Tuesday)	11	DENNIS C. MICAI, DIRECTOR FAX 609–989–0405	MERCER COUNTY BOARD OF SOCIAL SERVICES 200 WOOLVERTON ST., P.O. BOX 1450 TRENTON, NJ 08650–2099	609–989–4320
MIDDLESEX 8:30–4:15	12	ANGELA B. MACKARONIS, DIRECTOR FAX 732–745–4558 WFNJ FAX 732–745–4555	MIDDLESEX COUNTY BOARD OF SOCIAL SERVICES 181 HOW LANE, P.O. BOX 509 NEW BRUNSWICK, NJ 08903	732–745–3500
MONMOUTH 8:30–4:30 8:30–8:00 (Thursday)	13	KATHLEEN A. BRADY, DIRECTOR FAX 732–431–6017 WFNJ FAX 732–431–6267	MONMOUTH COUNTY DIVISION OF SOCIAL SERVICES KOZLOSKI RD., P.O. BOX 3000 FREEHOLD, NJ 07728	732–431–6000
MORRIS 8:30–4:30	14	CAROL A. NOVRIT, DIRECTOR FAX 973–326–7251	MORRIS COUNTY DIVISION OF EMPLOYMENT AND TEMPORARY ASSISTANCE PROGRAM SERVICES 1719C ROUTE 10 (PARSIPPANY), P.O. BOX 900 MORRISTOWN, NJ 07963–0900	973–326–7800
OCEAN 8:30–4:30	15	BEVERLY J. BEARMORE, DIRECTOR FAX 732–244–8075 WFNJ FAX 732–473–0669	OCEAN COUNTY BOARD OF SOCIAL SERVICES 1027 HOOPER AVE., P.O. BOX 547 TOMS RIVER, NJ 08754–0547	732–349–1500
PASSAIC 7:30–6:00	16	MARK SCHIFFER, DIRECTOR FAX 973–881–3232	PASSAIC COUNTY BOARD OF SOCIAL SERVICES 80 HAMILTON ST. PATERSON, NJ 07505–2060	973–881–0100
SALEM 8:00–4:00	17	AMY THOMAS, DEPUTY DIRECTOR FAX 856–299–3245	SALEM COUNTY BOARD OF SOCIAL SERVICES 147 S. VIRGINIA AVE. PENNS GROVE, NJ 08069–1797	856–299–7200
SOMERSET 8:15–6:00	18	MILDRED A. GAUPP, DIRECTOR FAX 908–231–9010	SOMERSET COUNTY BOARD OF SOCIAL SERVICES 73 E. HIGH ST., P.O. BOX 936 SOMERVILLE, NJ 08876–0936	908–526–8800
SUSSEX 8:30–4:30	19	JEFFREY M. DALY, DIRECTOR FAX 973–383–3627	SUSSEX COUNTY DIVISION OF SOCIAL SERVICES 18 CHURCH ST., P.O. BOX 218 NEWTON, NJ 07860–0218	973–383–3600
UNION 8:15–6:00	20	CHARLES J. GILLON, DIRECTOR FAX 908–965–3836 (Director Only) WFNJ FAX 908–965–2758	UNION COUNTY DIVISION OF SOCIAL SERVICES 342 WESTMINSTER AVE. ELIZABETH, NJ 07208–3290	908–965–2700
WARREN 8:30–4:30	21	HENRY D. DINGER, DIRECTOR FAX 908–475–1533	WARREN COUNTY WELFARE BOARD COURT HOUSE ANNEX SECOND & HARDWICK STS., BOX 3000 BELVIDERE, NJ 07823–3000	908–475–6301

rev. 6/1/01

Form #15

Amended by R.1997 d.354, effective September 2, 1997.
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Repealed Forms 7, 15 and 16, and recodified Forms 8 through 14, and 17, as Forms 7 through 13, and 14, respectively; and added Form 158.

Amended by R.2003 d.82, effective February 18, 2003.
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).