Georgia Department of Human Services
Division of Family and Children Services
Incurred Medical Expense (IME) Form Allowance For Non-Covered Services/Items

Name of Medicaid Member _____ Client ID _____

Medicaid ID# _____

Information for Medicaid Member

If you pay or owe for a medical service/Item that Medicaid does not cover, you may ask that you be allowed to keep more of your income to help you with the cost of the non-covered service. If you are allowed to keep more of your income and you have not paid your medical care provider, then you are to pay the provider promptly.

Ask your medical care provider to complete this form for you. Once completed by the provider, promptly return this form to your county Department of Family and Children Services for them to determine if you are allowed to keep more of your income.

Information for Medical Care Provider

If you provided a non-Medicaid covered service to this Medicaid member, we may allow this member to keep some extra income to either pay you for the debt owed or to keep it if there is no debt to you. If you are owed payment for your service, you must collect payment directly from the member.

Note to Pharmacist

Drugs that were denied for payment when the prior approval request was made or drugs that were denied for payment due to program requirements (exceeds age or quantity limit, non-rebate drug, DESI drug, etc.) are not allowed through the Incurred Medical Expense program. The doctor may prescribe an equivalent drug that would be paid by Medicaid, or the doctor may appeal a denial of payment for reconsideration of payment by Medicaid.

Please provide the information below for all services/items.

Name of Customer _____ **Cost of Service/Item** _____

Date of Service/Item _____

Description of Services/Item

Yes	No	Question
		Was this service/Item prescribed or ordered in writing by a doctor?
		Is the customer financially obligated to pay for the above service/Item?
		Are you a Medicaid-participating provider?

Please provide the information below if item was a drug.

NDC# _____ # Tablets_____ # Capsules_____ # Grams_____ # Milliliters_____

Yes	No	Question
		Is this a legend cough and cold medication?
		Is this a prescribed OTC drug or vitamin/mineral supplement?
		Was this drug denied for Medicaid payment after you requested prior approval?
		Was this drug denied for payment either because a generic was available for the prescribed brand (multi-source drug) or because the drug is a non-rebate drug or because it is a DESI drug or because it exceeds age or quantity limits?

_____ _____

Name of Medical Care Provider **Medicaid Provider Number**

_____ _____

Signature of Provider **Date**

The following are requirements for Form 942:

Field Name	Instructions
Name of Customer	Enter name of customer. If customer is not the applicant/recipient, the service/item cannot be considered as an IME.
Cost of Service/Item	cost of Rx , procedure, orthodic, etc.
Date of Service/Item	Enter date service or item was provided
Description of Services	Locate service/item on the IME Pricing Document that accompanies this form. Enter the Code and Service/Item Title as listed on the form. If the service/item provided is not listed on IME Pricing Document, enter detailed description including ICD-10 number and title.
Question "Was this service/Item prescribed or ordered in writing by a doctor?"	Enter Yes or No. Note: If no, then service/item cannot be considered as an IME.
Question "Is the customer financially obligated to pay for the above service/Item?"	Enter Yes or No. Note: If no, then service/item cannot be considered as an IME. *NOTE: Financially obligated means the item or service is not covered by Medicare or other health insurance and the item or service has not been written off or forgiven by the provider.*
Question "Are you a Medicaid-participating provider?"	Enter Yes or No.
Drug Information	If service/item is "drugs," provide the # of tablets or capsules and the # of grams or milliliters, give NDC#
Question "Is this a legend cough and cold medication?"	If service/item is "drugs," mark Yes or No.
Question "Is this a prescribed OTC drug or vitamin/mineral supplement?"	If service/item is "drugs," mark Yes or No.
Question "Was this drug denied for Medicaid payment after you requested prior approval?"	If service/item is "drugs," mark Yes or No.
Question "Was this drug denied for payment either because a generic was available for the prescribed brand (multi-source drug) or because the drug is a non-rebate drug or because it is a DESI drug or because it exceeds age or quantity limits?"	If service/item is "drugs," mark Yes or No.
Name of Medical Care Provider	Enter Provider name. Must be printed or typed.
Medicaid Provider Number	Enter provider's Medicaid Provider Number
Signature of Provider	Provider (Doctor, pharmacist, etc) must sign
Date	Provider enters date the form was completed.