COST SHARING REIMBURSEMENT REQUEST

For the period beginning on January 1, 2014 and ending on before November 30, 2015, only one request needs to be submitted on or before January 31, 2016. For subsequent quarters, requests must be submitted no later than 2 calendar months after the end of the quarter. All requests will be investigated no later than 4 months after the end of the quarter for which the request is being made (or 4 months after November 30, 2015 in the case of reimbursement requests for quarters from January 1, 2014 through November 30, 2015). A written response to this request will be sent no later than 15 days after the end of the investigation period. Only amounts of $5.00 or more will be reimbursed. Lesser amounts will be accumulated for up to 2 years.

ITEMS WITH AN **ASTERISK** * **MUST** BE ANSWERED OR COMPLETED IN ORDER TO PROCESS THE REIMBURSEMENT REQUEST.	
* Name of beneficiary:	
Quarter for which reimbursement request is being made:	
Insurance company (MCO):	
* Contract Number (MPI):	
* Mailing address (Please print clearly):	* Phone (s) #: ( )
	( )
FOR DIRECT DEPOSIT PLEASE INCLUDE:	
Financial Institution: (Bank):	

Routing number #:										Account #:	

Briefly explain why you understand the cost sharing limit established for your household was exceeded. Include information available about the limit and co-pays made. Remember the limit applies on a quarterly basis beginning on the effective date of your eligibility. This is not required to process the request but can be used as reference and may accelerate the reimbursement, if any. (If needed, attach additional sheets - include Beneficiary Name and Contract Number / MPI on each sheet).

AUTHORIZATION AND LEGAL WARNING

*I, _____ hereby authorize the PR Health Insurance Administration (ASES), to conduct the necessary investigation to process this reimbursement request, which may include Protected Health Information (PHI) as defined in federal and local laws. I am aware that providing false information with the purpose of obtaining a benefit constitutes fraud against the Medicaid Program and I can be referred to the pertinent authorities for processing.

_____	_____
* **Signature of beneficiary**	* **Date**
_____	_____
Signature of witness (if needed)	Name of witness

ASES/Medicaid internal use only

Name of employee receiving the request:
Date submitted:

By Mail: Send form to:

ASES – Customer Services
PO Box 195661
San Juan, PR 00919-5661

By Fax: Send form to:

787-474-3347