MONTHLY GRANT FUNDING (MGF) PAYMENT INQUIRY FORM

This form is intended to be used in those instances when a Community Partner clinic believes they should have received MGF for a MHLA enrolled participant with an allowable encounter in a prior 24 months, but did not. Please complete this form in its entirety for each patient the agency is inquiring as to lack of MGF payment. Submit this form within thirty (30) days of your most recent MGF payment. All fields must be filled out completely prior to submission or the form will be returned to the clinic. DHS-Finance will respond to this inquiry within thirty (30) days.

Please submit this form to: MHLAMGF@dhs.lacounty.gov

Today's Date: _____
Inquiry for The Payment Month Of: _____
Agency: _____ **Clinic Site**: _____

Was this participant enrolled in OEA for the month of inquiry? (Y/N) Please attach a screen shot showing the enrollment dates for this participant.	Was this participant enrolled at your Medical Home during the month of inquiry? (Y/N)	Did this participant have a valid visit in the prior 24 months and was the visit submitted within the submission deadline? (Y/N)	Did you confirm with AIA that the encounter claim for this patient was received (and not rejected) by AIA? (Y/N)

Participant Last Name	Participant First Name	Participant ID#	Participant Date of Birth	What was the participant's enrollment status during the month of inquiry? (i.e., disenrolled, enrolled, denied)	If you believe this participant was disenrolled or denied in error, please explain why.	Please provide the visit date, date submitted to AIA, and CPT code. (See attached for valid visit CPT codes.)		
						Visit Date	Date Submitted	CPT Code

Submitted by:_____ **Contact Number:**_____

Clinic Billing Manager, COO or CFO Signature: _____ **Please Print Manager's Name:** _____**Date:**_____