**MONTHLY GRANT FUNDING (MGF) PAYMENT APPEAL FORM**



Please complete this appeal form if your agency believes it should have received an MGF payment for a MHLA enrolled participant (who had an allowable encounter in the prior 24 months). Submit the form within 30 days of receipt of the MGF payment you are appealing. **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 with our determination within 30 days.

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

**Today’s Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appeal for The Payment Month Of**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agency**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Clinic Site**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Was each participant enrolled in OEA for the month of inquiry? (Y/N)**  **Please attach a screen shot showing the enrollment dates for each participant.** | **Was each participant enrolled at your Medical Home during the month of inquiry? (Y/N)** | **Did each 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 each patient was received (and not rejected) by AIA?**  **(Y/N)** |
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| **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** |
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**Submitted by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinic Billing Manager, COO or CFO Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please Print Manager’s Name: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_Date:\_ \_\_\_**