



Provider Request for Extended Repayment Plan

Provider Name: _____

Rendering Provider ID: _____

Office of Inspector General (OIG) Case Number (if applicable): _____

Medicaid Payee ID: _____ EIN/Fed Tax ID: _____

Critical Access Hospital: Yes _____ No _____

If not a Hospital, please indicate type of provider: _____

Request:

The above named Medicaid Provider requests a repayment plan for the amount due to the Georgia Department of Community Health (DCH) in the amount of \$ _____.

Please include a description of what the debt is related to (NH provider fee, hospital cost-settlement, etc.) along with a copy of the document from DCH requesting the refund – if applicable

Repayment Plan Requested: (Check One) Three Months _____ Six Months (Critical Access Only) _____
Twelve Months (Includes Fee) _____

I hereby certify that I am authorized to submit this form and that the information is true and accurate. I understand that the Department may recover any supplemental UPL or DSH payment or any other settlement or judgment due to the provider to accelerate repayment of debts owed to the Department.

Authorized Official:

Printed Name (Required)

Signature (Required)

Title (Required)

Date (Required)

Phone Number (Required)

Email Address (Required)

Completed form, with a signature, must be sent to the following email address: AR-inquiry@dch.ga.gov

Reserved for use by the Georgia Department of Community Health

Recoupment Amount \$ _____ Fee Amount \$ _____ Total Recoupment Amount \$ _____

Recoupment Start Date _____ Recoupment End Date _____

Reviewed by _____ Date of review _____

Date Request Approved _____ Denied _____

CFO Approval _____



DCH Policy Number 800.5.1

Medicaid Providers may request an extended repayment plan for any balance owed that is in excess of \$5,000. Providers seeking to obtain an extended repayment plan shall first complete the “Provider Request for Extended Repayment Plan” form available on the DCH website. Completed forms should be forwarded to the email address indicated on the form. Providers will be notified via email within three business days after submission of the form if their request has been approved.

For balances owed of \$5,000 or less, no extended repayment is offered. The department will recoup weekly amounts up to 100% of the weekly payment until the debt is satisfied. A hard copy check is an acceptable form of payment only if the provider is attempting to pay the debt off in full or if the provider has been terminated. A hard copy check is also acceptable if the provider does not receive a weekly payment for Medicaid services, therefore preventing an automated recoupment.

Providers may request one of the repayment plan options offered. If approved, equal weekly amounts will be deducted from the provider’s Medicaid and/or Peachcare benefit payments until the obligation is paid in full. The department will accept an initial partial payment from the provider at the outset of the repayment plan but thereafter recoupment against weekly payments is the accepted means of repayment. The department will also accept a terminal payment from a provider at any point in the repayment term.

Repayment plans ordered by a court will be followed accordingly and are not subject to this policy.

This Provider Extended Repayment Plan Policy is effective 9/1/2013. In those instances where existing informal or nonconforming repayment arrangements have been in effect, the department will consider those specific situations but in all cases the department retains the sole discretion to amend or adjust those arrangements to be consistent with this policy.

Provider repayment guidelines and options are as follows:

1. Repayment options are not available for balances of \$5,000 or less.
2. Providers may request a repayment term of three months with equal weekly recoupment. No fee shall be charged for this three month repayment term. Critical access hospitals are provided a six month repayment term with no fee assessed.
3. Alternatively, providers may request a repayment term of up to one year. For repayment terms in excess of the repayment term defined in #2, a 6% fee shall be applied to the outstanding balance and added to the total recoupment amount. The fee is non refundable and becomes part of the total balance owed once the established date of the Account Receivable is determined. The beginning date of the repayment term will be the established date of the Account Receivable. If the provider decides to pay the balance of the debt early, the balance and the fee must be remitted to the department.
4. For any debt not satisfied within the 12 month repayment period, the department may forward the unsatisfied debt to the Department of Law for collection.



5. If a provider requests and is approved for a repayment term as outlined in #2 and subsequently requests that the repayment be extended up to one year, the one year term shall be considered to have begun on the date of the original repayment term and the 6% fee shall be calculated on the original beginning balance. No repayment term shall be for a period of longer than twelve months.
6. Every approved Provider Extended Repayment Plan shall be separate and apart from any other approved Provider Repayment Plan for a particular provider. For example, if a hospital settlement for a hospital results in a balance due to the department and the provider is approved for an extended repayment plan and then a subsequent mass adjustment to a certain claim type results in another balance owed the department any extended repayment plan related to the new balance will apply irrespective of the first repayment plan.
7. DCH may, at its sole discretion, disallow an extended repayment plan. Reasons for this may include, but are not limited to, the following:
 - a. The department is aware or becomes aware that the provider is likely to become financially insolvent within the requested repayment term.
 - b. There is indication that the amount due DCH may have been the result of fraud or other inappropriate actions by the provider.

The preceding policy does not supplant, but may be in addition to, any statutory or court imposed interest and/or penalties.

Completed form, with a signature, must be sent to the following email address: AR-inquiry@dch.ga.gov

Any questions about completing the form should be directed to Mr. Said Tlemcani at (404) 656-4468.