01/01/2014

Provider Name
ATTN: Provider Name
Street Name
City, State Zip

Subject: **Request for Medical Records**
Letter Id: xxxxx
NPI: xxxxxxxxxx

Dear Provider:

This request for medical records/documentation is sent to you due to a recent review and discovery of potential overpayment of your Medicaid paid claim(s). In accordance with Title XIX of the Social Security Act, the implementing federal regulations 42 CFR Part 455, and the Mississippi Code of 1972, Title 43 Chapter 13 as amended, as a Medicaid participating provider, you must provide documentation and medical records upon request to support claims for Medicaid services. Your response is required even if you are unable to provide the requested documentation. Providing medical records of Medicaid patients is within the scope of compliance with the Health Insurance Portability and Accountability Act (HIPAA).

We are requesting medical record documentation regarding the claim(s) identified below. Please fax or mail the requested documents (see list below) and a copy of this letter for the identified claim to 1-877-520-7478 or mail to the following address:

PRGX USA, Inc.
Attn: Mississippi Overpayment Recovery Audit
P.O. Box 724888
Atlanta, GA 31139-9998

Upon receipt, our staff will review the documentation you submit for each claim to determine if the services billed are reasonable and necessary and meet all other requirements for Medicaid coverage. Following our review, we will inform you in writing of our findings.

In order to expedite the receipt and processing of your medical records/documentation, please submit no later than 03/20/2014, including a copy of this letter. The date indicated here is 30 days from the letter date.

Provider Contact Information:

In an effort to serve the provider community more efficiently, PRGX is requesting providers to establish a point of contact and update address information to facilitate communication. If you wish to make any changes to this communication regarding mailing address or point of contact information please call PRGX at 1-866-302-8320, fax at 1-877-520-7478 or mail the corrected information to:

PRGX USA, Inc.
Attn: Mississippi Overpayment Recovery Audit
P.O. Box 724888
Atlanta, GA 31139-9998

Thank you for your cooperation and prompt attention to this matter.

Letter Id: xxxxx
Provider Name #xxxxxxxxxx

Issue: Professional, Validate Units of Psychological Testing, CR, Medicaid, MS
Please provide copies of necessary documentation to support the psychological testing service billed. The type of documentation necessary to support the service includes:
• Documentation of Pre-evaluation background gathering session
• Copy of completed report
• Copy of consent for treatment
• Copy of consent to bill Medicaid
• Documentation of the evaluative tools (tests, rating instruments) used for testing
• Date, time in, time out, and amount of time spent assessing the child
• Date and amount of time spent preparing the report
• Copy of referral documentation from the referring provider
• Copy of feedback documentation given to referral source
• Copy of feedback documentation given to family

CLM	Patient Name	Dates of Service	Medicaid ID Number	TCN
1	John Doe	01/01/14	xxxxxxxxxxxxxxx	xxxxxxxx