MAP-34
(Rev. 04/09)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

HOME HEALTH AGENCY CERTIFICATION FOR DUAL ELIGIBLES

AGENCY INFORMATION

Name of Agency	
Provider ID #	
Agency Address	

RECIPENT INFORMATION

Name of Recipent	
Medicaid ID #	
Medicare HIC #	
DOS From:	
DOS To:	

This document serves to certify that benefits for Home Health Agency services has been utilized to the full extent of Title XVIII, Medicare benefits, under Part A and Part B and that the request for Program payment represents the Home Health Agency Services provided after exhaustion of benefits available under Title XVIII, Medicare, for the above- referenced program recipient.

☐ Rejected by Title XVIII – Medicare (Provide explanation in space to the right of the box) EOB denial	**Explanation:** _____
☐ Rejected by Home Health Internal Utilization Review Mechanism (Provide explanation in space to the right of the box) Identify specific code (HCPCS or Revenue) and reason for service or supply not covered by Medicare	**Explanation:** _____

I certify the above information is true, complete and correct to the best of my knowledge and belief.

_____ _____

Authorized Home Health Agency Representative **DATE**