

State of Idaho
Department of Health and Welfare
Repayment Agreement

Provider Name: _____

Provider # / NPI #: _____

Address: _____

Contact Name and Phone number: _____

FEIN: _____

Interim payment(s): \$ _____

The Department of Health and Welfare issued interim, non-claim payments, as part of the transition from HP/EDS to Molina. The Department plans to begin the recoupment process of the interim payments thirty days from the date of your notification letter at the rate of 25% of weekly paid claims unless you choose one of the following alternatives.

Option 1 _____ I elect to repay the entire amount with the enclosed check or money order.*

Option 2 _____ I elect to make four monthly installments in the amount of \$ _____ beginning with the enclosed check or money order.*

Option 3 _____ I elect to have _____ % (greater than 25%) of paid claims recouped.

Option 4 _____ I request a postponement of the recoupment. (Add a brief reason.)

NOTE: Any outstanding balances for these payments as of December 31 will be reported on the 1099 you will receive from the Department of Health and Welfare for the 2010 calendar year.

Name: _____

Signature: _____

Date: _____

*Please make all checks or money orders payable to: **Department of Health and Welfare**. Enclose a copy of this signed form with your payment.

You may fax the completed form to: 1 (208) 373-1425 or mail to:

Molina Medicaid Solutions

Attention: Finance Department

PO Box 70087

Boise, Idaho 83707

Molina will send you a receipt of your payment to the address above. If you have any questions, please contact Molina Provider Services, 1 (866) 686-4272.