

### AGENCY RESPONSE TO THE STATE QUALITY ASSURANCE (QA) MEDICAID FINDING

As described in Section XX of Appendix AL of the State and County Contract Covering Social Services and Community Programs, failure to take corrective action may result in liquidated damages. Complete, sign and return this form with documentation of corrective action to the following address:

Division of Health Care Access and Accountability  
Bureau of Program Integrity – Room 1050  
Attn: Medicaid Quality Assurance Program Supervisor  
P.O. Box 309  
Madison, WI 53701-0309

CARES Case Number	Case Name
-------------------	-----------

We agree with the error finding.

If necessary, correct the case and submit documentation of your corrective action within 30 days. Corrective action can include termination of current and future benefits, the calculation of overpayment amount and claims establishment, or restoration of benefits that were incorrectly under-issued, denied or terminated for all months affected by the error. If an overpayment occurred due to client error, established a claim to initiate benefit recovery. To assist with error reduction initiatives, indicate what information from the client, agency or state would have helped prevent this error? Please respond within 30 days of receipt of the QA error finding.

Additional Comments

We disagree with the error finding.

Provide additional information and / or documentation to explain why you consider the eligibility determination to be correct. Please respond within 10 days of receipt of the QA error finding.

Additional Comments

If client error, was this case referred for further investigation?  Yes  No

<b>SIGNATURE</b> – Agency Representative	Date Signed
<b>SIGNATURE</b> – Agency Supervisor	Date Signed

Agency Name