

TRANSMITTAL ADDENDUM: MAGI/NON-MAGI SORT



DATE: _____

NAME OF SUBMITTING ORGANIZATION	
ADDRESS	
CONTACT PERSON	PHONE

A completed copy of this addendum **must be submitted as the cover sheet to each individual case** that you are submitting for processing. Cases submitted without this addendum will **not** be accepted.

The application/applications listed below and detailed on the also attached case transmittal (check one)

<input type="checkbox"/> MAP-649	<input type="checkbox"/> MAP-2055n	<input type="checkbox"/> Other (specify) _____
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CASE NAME	SSN (last four digits)	REASON FOR SUBMISSION: (See Chart Below)						
		A	B	C	D	E	F	G
(check all that apply) ⇨								

A	Dual eligible evaluation: Medicaid and Medicare Savings Program						
B	Medicare Savings Program-only evaluation						
C	Surplus (Excess) Income Program evaluation						
D	SSI-Related budgeting (check one) ⇨	<input type="checkbox"/> DAB	<input type="checkbox"/> DAC	<input type="checkbox"/> MBI-WPD	<input type="checkbox"/> AHIP	<input type="checkbox"/> Pickle	
		<input type="checkbox"/> Widow(er) MA Continuation	<input type="checkbox"/> Congregate Care	<input type="checkbox"/> Other (specify) _____			

(continued on reverse side of page)

E	Hospital inpatient retroactive evaluation
F	Retroactive-only Medicaid evaluation for time period (beginning on)  _____ and ending on _____
G	Marketplace Transition Case. Consumer has Medicaid coverage on Marketplace Case with CIN _____. The case needs to be transitioned to MAP because of a: <input type="checkbox"/> Life event (specify) _____ <input type="checkbox"/> Special services need (specify) _____
H	Other (specify) _____ _____