

NH DEPARTMENT OF CORRECTIONS POLICY AND PROCEDURE DIRECTIVE	CHAPTER <u>Financial Services</u> STATEMENT NUMBER <u>3.17</u>
SUBJECT: <b>MEDICAL CARE REIMBURSEMENT</b>  PROPONENT: <u>Robert Mullen, Director</u> <i>Name/Title</i> <u>Administration</u> <u>271-5610</u> <i>Division</i> <i>Phone #</i>	EFFECTIVE DATE <u>11/01/13</u> REVIEW DATE <u>11/01/14</u> SUPERSEDES PPD# <u>3.17</u> DATED <u>04/15/04</u>
ISSUING OFFICER:  <hr/> <i>William Wrenn, Commissioner</i>	DIRECTOR'S INITIALS _____  APPENDIX ATTACHED: YES _____ NO _____
REFERENCE NO: See reference section on last page of PPD.	

I. PURPOSE:

To provide a mechanism to seek reimbursement from third party insurers for medical services provided to inmates of the Department of Corrections.

II. APPLICABILITY

To the Director of Administration, Prison Physicians, Wardens, the Director of Medical & Forensic Services and the Bureau of Financial Services

III. POLICY:

It is the policy of the Department of Corrections to seek reimbursement for medical care provided to incarcerated persons and committed residents from any insurer to the extent that said insurer would be liable to pay for such medical care pursuant to any health, medical, group health or liability, or other insurance policy.

IV. PROCEDURES:

1. Immediately upon arrival, the intake officer will have the inmate/resident complete the Medical Insurance Questionnaire (Attachment 1).
2. The data will be keyed into the system for Offender Record purposes and the completed and signed insurance questionnaire will be forwarded to the Bureau of Financial Services.
3. If an HMO or other health insurance provider covers the inmate, Financial Services will retain a copy and send a copy of the questionnaire to Medical Records who will make a notation on the Problem List. Should the inmate request treatment, the DOC Operations Administrator in consultation with the Chief Medical Officer will be responsible for making the decision whether it is feasible to send the inmate to their primary care physician. Prior to referral to their primary care physician, confirmation of coverage must be obtained from the insurance company. The DOC Operations Administrator must request that Financial Services confirm that the insurance is still in effect. Upon confirmation, the DOC physician will complete a consult sheet to arrange an appointment. The insurance information will be attached to the consult form and provided to the transportation team to assure the appropriate parties are billed for the services rendered.
4. The health care provider will submit a claims form to the inmate's primary insurance

carrier for payment.

REFERENCES:

Standards for the Administration of Correctional Agencies  
Second Edition Standards

Standards for Adult Correctional Institutions  
Fourth Edition Standards

Standards for Adult Community Residential Services  
Fourth Edition Standards

Standards for Adult Probation and Parole Field Services  
Third Edition Standards

Other

MULLEN/clr

Attachment

MEDICAL INSURANCE QUESTIONNAIRE

INMATE/ RESIDENT NAME \_\_\_\_\_

CORIS ID #: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SOCIAL SECURTY # \_\_\_\_\_

ARE YOU COVERED BY ANY INDIVIDUAL OR GROUP HEALTH OR MEDICAL PLAN?  
YES  NO

NAME OF INSURANCE CO. \_\_\_\_\_

ADDRESS OF INSURANCE CO. \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_

MEMBER CERTIFICATE OR ID # \_\_\_\_\_

POLICY # \_\_\_\_\_

NAME OF SUBSCRIBER \_\_\_\_\_

RELATIONSHIP OF SUBSCRIBER TO INMATE \_\_\_\_\_

IF YOU ARE COVERED BY AN HMO, PLEASE FURNISH THE FOLLOWING INFORMATION

NAME OF PRIMARY CARE PHYSICIAN \_\_\_\_\_

ADDRESS OF PRIMARY CARE PHYSICIAN \_\_\_\_\_

\_\_\_\_\_  
INMATE SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_  
DATE