Billing and Medicaid (Apple Health)

Author
Northwest Justice Project

Last Review Date
April 29, 2025

Read this if your medical provider didn't bill Medicaid for services when you think they should have. Includes form letters you can use to try to resolve the situation.

1. Protection from billing

If you're on Medicaid, in Washington State called Apple Health (https://www.hca.wa.gov/about-hca/programs-and-initiatives/apple-health-medicaid), a medical provider usually can't bill you, or someone related to you, such as your family, a friend, or helper, for services. **Providers who take part in Apple Health must accept payment from the agency as payment in full**.

- A provider can't bill you for the cost of services over and above what Apple Health pays.
- A provider generally can't bill you for any service Apple Health covers even if the provider hasn't gotten payment from Apple Health or your

managed care provider.

There are exceptions to these rules. This guide discusses the exceptions. If no exception applies to you, the provider can't bill you.

If the provider tries to bill you anyway, try using one of our form letters. And try to talk to a lawyer.

2. You didn't sign

If you don't sign documents the provider gives you**,** such as insurance forms, billing documents, or other forms the provider needs to bill a third-party insurance carrier, the provider may bill you for the service.

3. Out-of-state services

Generally, an out-of-state provider can bill you for services. But Apple Health will pay for services you traveled to receive in these **bordering cities** the same as in-state care:

- Coeur d'Alene, Moscow, Sandpoint, Priest River, and Lewiston, Idaho.
- Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria, Oregon.

Apple Health will also pay for emergency and non-emergency out-of-state care that meets state requirements (https://app.leg.wa.gov/WAC/default.aspx?cite=182-501-0180).

4. Canadian providers

If you received services in British Columbia, Canada, the provider may be able to bill you directly. Apple Health will pay only if your situation meets other requirements. For example, you live in Point Roberts, or in a community along the Washington/British Columbia border. Or you're a member of the Canadian First Nations and live in Washington State.

Providers in other Canadian provinces can always bill you if you're on Apple Health.

5. Noncovered services

A provider can bill you for services that Medicaid doesn't cover if you agreed to pay the provider after it did all these:

1. Checked if you could get Medicaid coverage for the dates of service.
2. Checked if you had coverage under a Managed Care Organization.
3. Told you the limits of your coverage and services available to you.
4. Signed a written agreement with you. The provider generally should use this agency form (https://www.hca.wa.gov/assets/billers-and-providers/13_879.pdf).
5. Provided translation into another language if needed.
6. Did everything Medicaid or your Managed Care Organization required of it to authorize services, if coverage or authorization was available.

> A provider who didn't complete the right paperwork at the right times can't bill you if Medicaid or your Managed Care Organization won't pay the provider.

If the provider should have had a written agreement with you, ask them to give you a copy. Compare the agreement you signed to what WAC 182-502-0160(5) (https://app.leg.wa.gov/WAC/default.aspx?cite=182-502-0160) requires. If the agreement doesn't say what it should, you can send the provider a letter explaining why they shouldn't bill you, and try to talk to a lawyer.

6. Provider doesn't take Medicaid

A provider who doesn't take Medicaid may bill you if you chose to receive their services even after they informed you that they don't contract with Medicaid, and Medicaid wouldn't pay for the services.

7. Cost sharing

If your Medicaid plan includes cost sharing, your medical provider can bill you for some costs. The provider can also bill you directly for

- Costs such as deductibles, coinsurance, or copayments.

- Services within your spend down amount, if you get Medically Needy Medicaid.

8. Managed Care Organization (MCO)

If you're in an MCO, and you go to an out-of-network provider for services, the provider can bill you if both are true:

- You knew the provider was outside your MCO's network.
- You chose to get nonemergency services from that provider anyway without the MCO's authorization.

9. Third parties

A medical provider can bill a "third party" who is legally responsible for paying any of the cost of your health care. This can be

- A person or entity that has caused you mental or physical harm.
- The insurance company covering that person or entity.
- Both.

Example: You're in a car accident. The other driver is at fault. Medicaid pays for the medical services for your injuries. It will then try to recover the cost of your medical services from the other driver or their insurance company.

> You must "assign" (give) the State any right you have to payment from a liable third party for medical expenses, assistance, or residential care.

10. Dates not covered

A provider can bill you if you didn't have Medicaid for the dates you received services. Compare the dates of services to notices you got from Apple Health, your online account, or call the number on the back of your ProviderOne card. If the provider is billing you for any dates that you had Medicaid, you can send them a letter explaining why they should stop billing you, and try to talk to a lawyer.

> If you tell the provider you're a private pay client and not getting medical assistance, the provider will bill you directly, even if you do in fact get Medicaid.

To check if you were covered by Medicaid for the dates of service, contact the Medical Assistance Customer Service Center (MACSC) (https://www.hca.wa.gov/free-or-low-cost-health-care/contact-washington-apple-health-medicaid).

11. Form letters

Form attached:

Letter to health care provider re: Medicaid coverage (NJP Health 782)

Form attached:

Letter to collection agency re: Medicaid coverage (NJP Health 783)

Tips for using form letters

Keep a copy of the letters you send. Make a note on your copy of how you delivered the letter and the date you delivered it. For example, “sent on 8/22/2024 by regular US mail” or “hand-delivered to [provider name] billing dept. on 8/22/2024”.

NJP Health 782 - Letter to health care provider re: Medicaid coverage: Use this if you’re getting bills from a provider even though you told them at the time of service that you had Medicaid.

NJP Health 783 - Letter to collection agency re: Medicaid coverage: Use this letter to a collection agency if Medicaid covered some, but not all, of your bills, and the provider claims you signed a waiver allowing them to bill you.

Date: _____

To:

_____
Name of provider

_____
Street address

_____

_____
City, state and zip

Re: Account Number _____

You sent me a bill for services in the amount of $ _____ for services I got from you on (*dates of service*) _____. I had Medicaid when I got those services. I'm getting bills on this account even though I told you I was on Medicaid at the time of service. Please immediately correct your records to reflect that I have no liability for this bill.

It's illegal for a provider to bill a Medicaid recipient. WAC 388-502-0160. The federal government provides penalties for providers who bill Medicaid recipients, up to three times the amount of the bill. 42 CFR §447.21. It's your responsibility to verify coverage. You can't charge me even if Medicaid doesn't pay. WAC 388-502-0160 (1).

Please send me written confirmation that you will cease any efforts to collect this bill, or any other bill incurred while I had Medicaid coverage. If you've notified any credit reporting agencies of a delinquency, please correct that report and send me proof that you've done so. Thank you for your prompt attention to this matter.

Sincerely,

_____ _____
Sign here *Print name*

_____
Street address

_____
City, state and zip

_____
Phone number / Email - optional

Date: _____

To:

_____
Name of collection agency

_____
Street address

_____

_____
City, state and zip

Re: Account Number _____

Some or all the bills listed in the letter you sent me from (*name of health care provider*) _____ dated _____ detailing the charges at issue were for Medicaid-eligible services.

Enclosed please find information from the Health Care Authority showing that, of the dates in question, I was on Medicaid from (*date*) _____ through (*date*) _____. I informed the provider about my coverage. They knew I had Medicaid.

Even if you believe the provider's claim that I didn't disclose my Medicaid status, it doesn't matter. It's the provider's responsibility to verify medical coverage. WAC 182-502-0160(2).

The provider has also argued that Medicaid may not have covered the services, and that I signed waiver forms authorizing the service. The waiver forms I signed don't comply with WAC 182-502-0160(5), which reads:

(a) The agreement must:

(i) Indicate the anticipated date the service will be provided, which must be no later than ninety calendar days from the date of the signed agreement;

(ii) List each of the services that will be furnished;

(iii) List treatment alternatives that may have been covered by the agency or agency-contracted MCO;

(iv) Specify the total amount the client must pay for the service;

(v) Specify what items or services are included in this amount (such as pre-operative care and postoperative care). See WAC 182-501-0070(3) for payment of ancillary services for a noncovered service;

(vi) Indicate that the client has been fully informed of all available medically appropriate treatment, including services that may be paid for by the agency or agency-contracted MCO, and that he or she chooses to get the specified service(s);

(vii) Specify that the client may request an exception to rule (ETR) in accordance with WAC 182-501-0160 when the agency or its designee denies a request for a noncovered service and that the client may choose not to do so;

(viii) Specify that the client may request an administrative hearing in accordance with chapter 182-526 WAC to appeal the agency's or its designee denial of a request for prior authorization of a covered service and that the client may choose not to do so;

(ix) Be completed only after the provider and the client have exhausted all applicable agency or agency-contracted MCO processes necessary to obtain authorization of the requested service, except that the client may choose not to request an ETR or an administrative hearing regarding agency or agency designee denials of authorization for requested service(s); and

(x) Specify which reason in subsection (b) below applies.

(b) The provider must select on the agreement form one of the following reasons (as applicable) why the client is agreeing to be billed for the service(s). The service(s) is:

(i) Not covered by the agency or the client's agency-contracted MCO and the ETR process as described in WAC 182-501-0160 has been exhausted and the service(s) is denied;

(ii) Not covered by the agency or the client's agency-contracted MCO and the client has been informed of his or her right to an ETR and has chosen not to pursue an ETR as described in WAC 182-501-0160;

(iii) Covered by the agency or the client's agency-contracted MCO, requires authorization, and the provider completes all the necessary requirements; however the agency or its designee denied the service as not medically necessary (this includes services denied as a limitation extension under WAC 182-501-0169); or

(iv) Covered by the agency or the client's agency-contracted MCO and does not require authorization, but the client has requested a specific type of treatment, supply, or equipment based on personal preference which the agency or MCO does not pay for and the specific type is not medically necessary for the client.

(c) For clients with limited English proficiency, the agreement must be the version translated in the client's primary language and interpreted if necessary. If the agreement is translated, the interpreter must also sign it.

(d) The provider must give the client a copy of the agreement and maintain the original and all documentation which supports compliance with this section in the client's file for six years from the date of service. The agreement must be made available to the agency or its designee for review upon request; and

(e) If the service is not provided within ninety calendar days of the signed agreement, a new agreement must be completed by the provider and signed by both the provider and the client.

This situation doesn't fall into one of WAC 182-502-0160(6)'s limited exceptions where a provider may bill a patient without executing the Agreement to Pay for Healthcare Services.

For the period I had Medicaid, representing $_____ of the $_____ billed, the provider violated the law by billing or trying to collect the charges from me. I have a refund coming from the provider for all improperly charged amounts you have collected from me.

Please cease all further collection attempts immediately. Thank you.

_____ _____

Sign here *Print name*

_____

Street address

_____

City, state and zip

_____

Phone number / Email - optional