SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Request for Retroactive Medicaid Coverage

Please complete this form to see if you qualify for retroactive Medicaid coverage. Retroactive coverage means that Medicaid may cover your medical bills dating back to three months before your application date. Provide information for anyone in your household who has medical bills in the three months prior to your application date.

Application ID#

Today's Date

Application Date

Please return this form within 15 days from the date listed above.

I. Household Information

Person 1

1. First name, Middle name, Last name, & Suffix

2. Date of birth (mm/dd/yyyy)

Person 2

1. First name, Middle name, Last name, & Suffix

2. Date of birth (mm/dd/yyyy)

Person 3

1. First name, Middle name, Last name, & Suffix

2. Date of birth (mm/dd/yyyy)

Person 4

1. First name, Middle name, Last name, & Suffix

2. Date of birth (mm/dd/yyyy)

II. Income Information

You may be asked to provide proof of income for each month you need coverage or for additional information about your household. Please note that proof of income should be for the entire household--this may be a copy of an itemized check stub, award letter, printout, or statement on letterhead from the company or agency.

1. Was your household size the same in the three months prior to the date you applied for Medicaid? (See Application Date above.) ☐ Yes ☐ No

2. Enter your total montly income in the three months prior to the date you applied for Medicaid:

Month 1: $_____ Month 2: $_____ Month 3: $_____

III. Mail the Completed Form

It is very important that you provide all requested information to avoid delays in your application being processed.

Mail the completed form to:

SCDHHS - Central Mail
PO Box 100101
Columbia SC
29202-3101

OR

Fax the completed form to:

(888) 820-1204

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, please contact the Americans with Disabilities Act (ADA)/Civil Rights Official by mail at: PO Box 8206, Columbia, SC 29202-8206, by phone at: 1-888-549-0820 (TTY: 1-888-842-3620), or by email at: civilrights@scdhhs.gov.

If you believe SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person, by mail, or via email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html