**441—75.20(249A) Medical assistance corrective payments.** If a decision by the department or SSA following an appeal on a denied application for any of the coverage groups set forth in 441—75.3(249A) through 441—75.8(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular Medicaid coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

**75.20(1)** These bills must be for services covered by the Medicaid program as set forth in 441—Chapter 78.

**75.20(2)** Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

**75.20(3)** If a county relief agency has paid medical bills on the member's behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the member.

**75.20(4)** Members and county relief agencies may file claims for payment under this subrule on forms prescribed the department. These forms are available from the county office. All requests for reimbursement will be acted upon within 60 days of receipt of the forms in the county office.

**75.20(5)** Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 2506.

[**ARC 9763C**, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]