DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

**TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 09-002

2. STATE: GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2009

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1902(r)(1)(A)(ii) of the Act

7. FEDERAL BUDGET IMPACT:
FFY 2009 $0
FFY 2010 $0

"8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 3 to Attachment 2.6-A, page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Supplement 3 to Attachment 2.6-A, page 1

10. SUBJECT OF AMENDMENT:
REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: JERRY DUBBERLY

14. TITLE: CHIEF, MEDICAL ASSISTANCE PLANS

15. DATE SUBMITTED:

16. RETURN TO:

Department of Community Health
Medical Assistance Plans
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: 05/29/09

18. DATE APPROVED: 08/10/09

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 04/01/09

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Mary Kaye Justis, RN, MBA

22. TITLE: Acting Associate Regional Administrator
Division of Medicaid & Children's Health Opns

23. REMARKS: