MEDICAL PROVIDER VERIFICATION FORM

_____
(Date)

_____ County Department of Social Services

_____

_____

_____

Re:_____
(Applicant/Recipient)

_____
(County Case Number)

_____
(Patient's Name)

_____
(Relation to App./Recip.)

Dear Medical Provider:

The individual named above is seeking to meet a Medicaid deductible with charges for medical services provided by you for a member of the applicant/recipient's family. We appreciate your information for any services provided from _____ _____ _____ through _____ _____ _____, which is 24 months prior to the application date or deductible period.

_____
Income Maintenance Caseworker

_____ _____
Date(s) of Service) (Type of Service)

$_____ _____
(Amount of Total Charge) (Date of Latest Payment on Account)

Third Party Payments

_____Insurance Filed _____Amount of Payment
_____Insurance Paid/Denied _____Additional Payments Anticipated
_____Any Other Third Party Payment

Current Patient Responsibility

This account is still the patient's responsibility. _____Yes _____No
I expect payment from the patient for the unpaid balance of $_____.

_____ _____
(Date) (Medical Provider)

DMA-5037
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