MEDICAL DEDUCTION SUPPLEMENT

Case Name: _____ **County Case No:** _____
FSIS Case ID: _____ **Certification Period:** _____
FSU Members Claiming Expenses:

Method of Verification (V)-

1. Current bills/receipts
2. Provider's statement
3. Pharmacy printout
4. Insurance policy or forms
5. Medicare- Explanation of Benefits
6. DMA-5036, Record of Medicaid Deductible
7. DSS-8194 from Medicaid

Frequency of Expenses (FQ):

A. Recurring/Ongoing
B. Less often than monthly
C. One-time-only
D. Paid out/terminated

Reimbursement Status (RS):

N. None expected
P. Pending
V. Verified amount
E. Expected reimbursement

Indiv.. #	Expense Provider / Type	Date Incur'd	Date Rec'd	Total Expense	(-) Reimb. Amount	RS	(=) Allowed Expense	FQ	Monthly Total	V
							0.00		10.00	
							0.00			
							0.00			
							0.00			
							0.00			
							0.00			
							0.00			
							0.00			
							0.00			
							0.00			
							0.00			
							0.00			
							0.00			
							0.00			
							0.00			
							0.00			
							0.00			
							0.00			
							0.00			
							0.00			

Subtotal	10.00
(+)Back page Total	0.00
(MONTHLY) GRAND TOTAL	10.00

Indiv. #	Expense Provider / Type	Date Incur'd	Date Rec'd	Total Expense	(-) Reimb.. Amount	RS	(=) Allowed Expense	FQ	Monthly Total	V
							0.00			
							0.00			
							0.00			