DMA-5037(11/87)

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 will appreciate your information:

_____
Eligibility Specialist

_____ _____
(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 $_____.

_____ _____

MA-3325-Figure 1

(Date) (Medical Provider)

MA-3325-Figure 1