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 $______________.

______________________________ (Date)

______________________________ (Medical Provider)

DMA-2360-Figure 1