

Request For Reimbursement For Non-Medicaid OMHC Services

Name

Provider

Street Address

Provider Number

City State Zip

Date of Birth

Social Security Number

Applied for: Medical Assistance _____
Date

Pharmacy Assistance _____
Date

Annual Income: _____

Source: _____

Monthly Income: _____

Dependents: _____

Clinical Indications for Continued OMHC Services:

Requestor: _____

Date of Request: _____

Phone Number: _____

Fax Number: _____

CSA approves reimbursement:

Yes _____

No _____

Ten (10) visits _____

Signature CSA

Date