

**Urgent Service (Initial)  
Request For Reimbursement For Non-Medicaid OMHC Services**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Provider

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Provider Number

\_\_\_\_\_  
City                      State                      Zip

Medical Assistance                      \_\_\_\_\_  
Application Date

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

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**Clinical Indications for Urgent OMHC Services:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Requestor: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_

Date of Request: \_\_\_\_\_

CSA approves reimbursement:

Yes \_\_\_\_\_                      No \_\_\_\_\_                      Two (2) visits \_\_\_\_\_

\_\_\_\_\_  
Signature CSA

\_\_\_\_\_  
Date