CLAIM TRANSMITTAL FORM

LOCAL DISTRICT:		**Page ___of ____**	
RECIPIENT NAME:	CLAIMANT'S SSN:	APPLICATION DATE:	ELIGIBLE From: To:
RECIPIENT ADDRESS:		CLIENT IDENTIFICATION NO.	
REPRESENTATIVE NAME, ADDRESS, AND SOCIAL SECURITY NO. (if applicable)			

NAME AND ADDRESS OF SERVICE PROVIDER	MEDICAID PROVIDER ID#	DESCRIPTION OF SERVICE PROVIDED (For Prescription Drugs, Show Name, Strength and Quantity)	DATE OF SERVICE (MO/DAY/YR)	TOTAL BILL	INSURANCE PAYMENT	AMOUNT PAID (After Insurance Payment and Spend-down, if any)

I certify that the above-named recipient is eligible for reimbursement of paid medical expenses and/or the above-named FHPlus provider is eligible for reimbursement for unpaid medical expenses for the time period indicated above. This claim is a result of:

- ☐ Expenses paid due to agency error
- ☐ Expenses paid due to agency delay
- ☐ Expenses paid in the 3 mo. period prior to the mo. of application (limited to Medicaid rate/fee)
- ☐ Expenses paid between the date of application and receipt of the CBIC (limited to Medicaid enrolled providers and Medicaid rate/fee)
- ☐ FHPlus unpaid expenses
- ☐ Other _____
  _____

CASE TYPE_____

DATE COMPLETED_____

X _____
SIGNATURE OF LDSS ELIGIBILITY WORKER