MEDICAL ASSISTANCE REIMBURSEMENT DETAIL FORM

_____Department of Social Services Recipient Name: _____

Case #:_____

BILLS SUBMITTED FOR PAYMENT			REASON WE WILL NOT PAY OR WILL PAY ONLY PART OF BILL			
DATE OF BILL	NAME OF PROVIDER DESCRIPTION OF SERVICE	AMOUNT OF BILL	MAXIMUM PAYABLE BY MEDICAL ASSISTANCE	TPHI SPENDDOWN AMOUNT	AMOUNT WE WILL PAY	OTHER: - Service Dates Not Covered - Ineligible Service - Missing Information - Etc.