FINANCIAL SERVICE AGENCY

For Non-Provider Reimbursement

MUST ATTACH RECEIPT, INVIOCE or BILLTO RECEIVE PAYMENT

Medicaid ID # ______________________

Date Item Purchased
or Service End Date _ _ / _ _ / _ _ _ _

Pay To
Participant Name: ______________________________________
(please print)

phone no. _ _ _ - _ _ _ - _ _ _ _

Description of Provided
Goods or Services: ____

Service Code _ _ _ _

Unit Type: _______________
(each, hour, day, etc.)

Unit Rate: $ ______________

Amount: $__________________________________

No. of units: _______________

Approved ____ Date _ _ / _ _ / _ _ _ _
(Participant/Participant's representative signature)

**Reminder: Reimbursement amounts should NOT exceed $300. Receipts or Invoice MUST be attached.*