CLAIM TRANSMITTAL

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 (For Prescription Drugs, Show Name, Strength and Quantity. Also include National Drug Code and/or Procedure Code)	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

OHIP-0031 (07/2014)