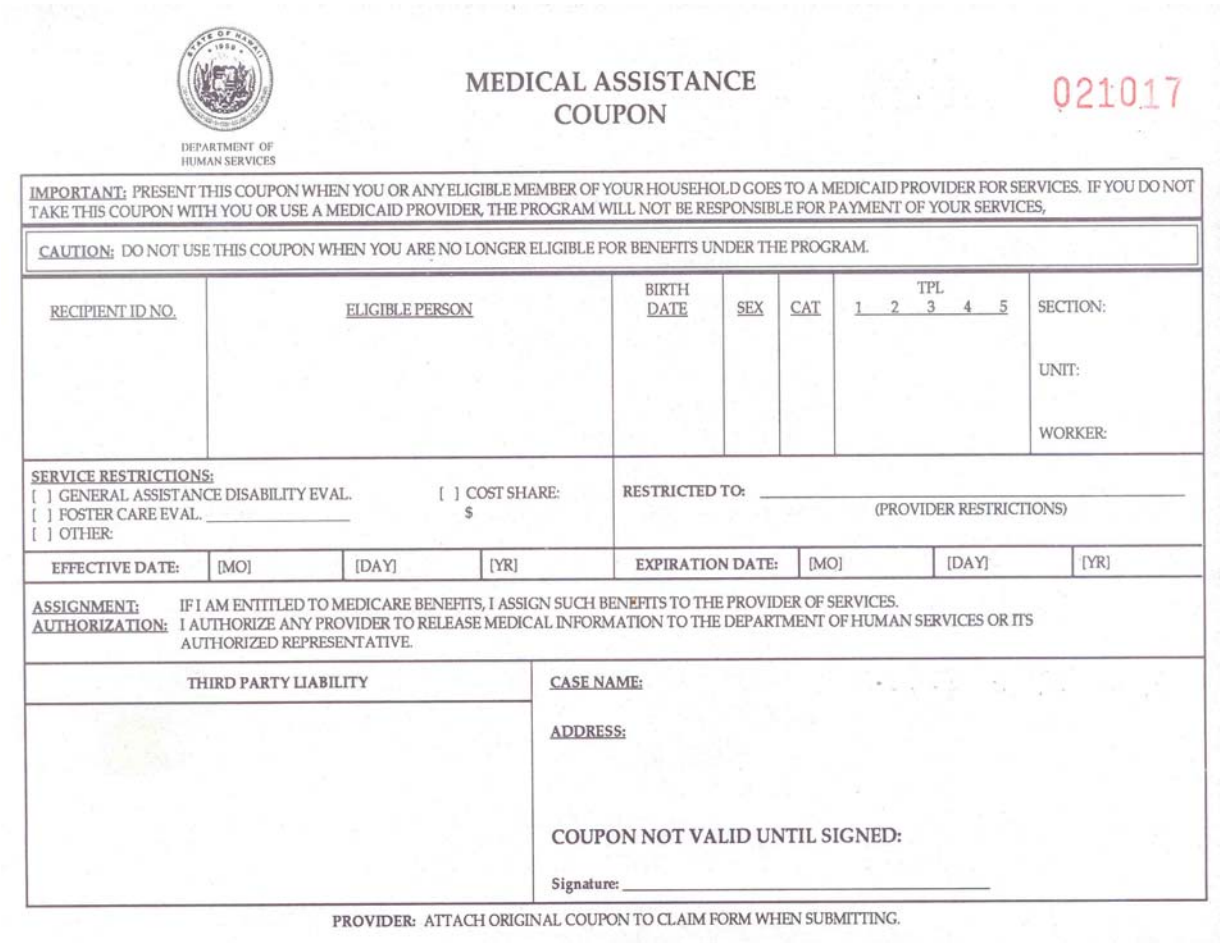

DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE COUPON

021017

IMPORTANT: PRESENT THIS COUPON WHEN YOU OR ANY ELIGIBLE MEMBER OF YOUR HOUSEHOLD GOES TO A MEDICAID PROVIDER FOR SERVICES. IF YOU DO NOT TAKE THIS COUPON WITH YOU OR USE A MEDICAID PROVIDER, THE PROGRAM WILL NOT BE RESPONSIBLE FOR PAYMENT OF YOUR SERVICES,

CAUTION: DO NOT USE THIS COUPON WHEN YOU ARE NO LONGER ELIGIBLE FOR BENEFITS UNDER THE PROGRAM.

RECIPIENT ID NO.	ELIGIBLE PERSON	BIRTH DATE	SEX	CAT	TPL 1 2 3 4 5	SECTION: UNIT: WORKER:

SERVICE RESTRICTIONS:
[ ] GENERAL ASSISTANCE DISABILITY EVAL.
[ ] FOSTER CARE EVAL. _____
[ ] OTHER:
[ ] COST SHARE: $

RESTRICTED TO: _____ (PROVIDER RESTRICTIONS)

EFFECTIVE DATE:	[MO]	[DAY]	[YR]	EXPIRATION DATE:	[MO]	[DAY]	[YR]

ASSIGNMENT: IF I AM ENTITLED TO MEDICARE BENEFITS, I ASSIGN SUCH BENEFITS TO THE PROVIDER OF SERVICES.
AUTHORIZATION: I AUTHORIZE ANY PROVIDER TO RELEASE MEDICAL INFORMATION TO THE DEPARTMENT OF HUMAN SERVICES OR ITS AUTHORIZED REPRESENTATIVE.

THIRD PARTY LIABILITY	CASE NAME:
	ADDRESS:
	COUPON NOT VALID UNTIL SIGNED:
	Signature: _____

PROVIDER: ATTACH ORIGINAL COUPON TO CLAIM FORM WHEN SUBMITTING.