Provider Medicaid Reimbursement Form

Name:

Date:

Job Title/Provider Group:

Location:

Phone Extension and email:

Please list the item(s) purchased, for which you are seeking Medicaid reimbursement.

Dollar amount (INCLUDE shipping & handling): _____

Number of students who might benefit from this purchase: _____

Please explain:

How this purchase relates to student health and/or safety. The purchase must be used to enhance health (medical, dental, mental) related services for all students. We cannot reimburse for educational or items used for purely academic purpose. Please also explain how this item relates to your scope of practice:

***Reminder - we cannot reimburse for items that are for *academic* purposes.**

Provider's Signature: _____

Point Person's Signature: _____

Medicaid Coordinator's Signature: _____

Please attach receipts or order to this form and send to the Medicaid Office
Attn: Miriam Yeo @ ESC 3.
Thank you!