

State of Maryland

REQUEST FOR REIMBURSEMENT FOR NON-MEDICAID OUTPATIENT SERVICES 01/27/2011

(Form to be sent by CSA to ValueOptions if approved)

Case Management Services Approved (check only if this is Case Management)

Hospital Diversion

Uninsured Coverage – CSA Exception

FOR PROVIDER USE ONLY:		Eligibility Fax: 1.855.378.8310	
Value Option (VO) Provider Number:		Provider Name:	
Provider Contact Name:		Provider Phone Number:	
Provider Fax Number:		Provider Email Address:	
CONSUMER INFORMATION:			
Registration Date:		Consumer or Medicaid ID:	
Last Name:	First Name:	Middle Initial:	Suffix:
Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> UNK		
Date of Birth:	SSN:	<input type="checkbox"/> No SSN <input type="checkbox"/> Unknown SSN	
Primary Address:	Street:		
	City:		
	State:		
	Zip:		
	County:		
	Phone:		
FOR CSA USE ONLY:			
	<input type="checkbox"/> Approved <input type="checkbox"/> Denied		
Reason for Exception or Denial:	 		
CSA Name:			
	CSA Email:		
	CSA Phone Number:		
	CSA Fax Number:		
Comments:	 		

FOR VALUEOPTIONS USE ONLY:	
Consumer ID:	
Comments:	