MEDICAID REIMBURSEMENT REQUEST FORM	Today's date

DIRECTIONS: Complete and return, with receipts, within 6 months after you went to the clinic, doctor, hospital, or pharmacy – or 6 months of the date you learned you were eligible for Medicaid – to:

Recipients Claims Research Team
DC Department of Health Care Finance
441 4th Street NW - 900 South
Washington, DC 20001

Please give as much information as you can. Attach copies of your receipts. If you don't have a receipt, attach a signed and dated letter that explains why you don't have it. If you're asking for reimbursement of expenses from more than 1 provider (like a doctor *and* a pharmacy), please use separate lines for each.

Your Name	**Mailing Address**	**Your phone numbers**
		Day
Social Security Number of Medicaid Recipient		Evening
		Cell
Birth Date of Medicaid Recipient	**Name & Medicaid ID # of Recipient Requesting Reimbursement**	

SUMMARY OF INFORMATION ON ATTACHMENTS

For each expense (drug prescription, doctor visit or hospitalization), give this information*

Date (or estimated date) of expense	Name and address of pharmacy, clinic, doctor or hospital	How much you paid	How much you still owe	How much any other insurance paid	How much you want Medicaid to reimburse

*Attach copies of any letters or bills from the pharmacy, clinic, doctor or hospital; or letters from credit collection companies about the bill.

I swear and declare, under penalty of perjury, that the statements I made on this paper and on any attached papers are true and correct.

Signature

Version Feb.2025