|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Children with Special Health Care Needs (CSHCN) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Health Services Authorization** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Asterisk (\*) = Required Data for Payment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | AUTHORIZATION NO. | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Patient\*: | | | |  | | | | | | | | | | | | |  | 2. ProviderOne (P1) ID\* | | | | | | | | | |  | | | | | | | | |
|  | | | |  | | | | | | | | | |  | | | | 3. Chif ID (if P1 not available) | | | | | | | | | |  | | | | | | | | |
| 4. Address: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | 10. Birth Year\* | | | | | | | | |
| 5. Diagnosis\*: | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | 11. County of Residence & Code\* | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | **Return Authorization By** | | | | |  | | | | | | | | |
| 6. Vendor or  Provider\* | | | | 12. Authorization Date\* | | | | | | | | |
|  | | | | | | | | |
|  | | | | 13. Authorization Expires\* | | | | | | | | |
|  | | | | | | | | |
| 7. Vendor/Provider Federal Tax ID No.\* | | | | | | | | | | | 8. Vendor/Provider NPI | | | | | | | 9. Vendor/Provider Taxonomy | | | | | | | | | | 14. Insurance/Policy No./Name\* | | | | | | | | |
|  | | | | | | | | | | |  | | | | | | |  | | | | | | | | | |  | | | | | | | | |
| You are authorized to perform the following services for which CSHCN will be obligated to pay their fee, according to currently established payment policy or fee schedule. For payment questions and additional services not specified nor ordinarily included as a part of the description, contact local agency indicated at bottom. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. CPT/HCPCS/DOH\* | | | | | | | 16. Description/Date(s) of Service(s)\* | | | | | | | | | | | | | | | | | | | 17. Amount Authorized | | | | | | | | | 18. For Agency Use | |
|  | | | | | | | |  | | --- | | Description: |   Begin Date Of Service(s)  End Date Of Service(s) | | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | |
| Vendor/Provider of Service agrees to accept CSHCN fee as payment in full and that no additional charge will be made to the patient or his/her family for these services. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19. I certify that all services represented by this voucher have been provided without discrimination on the grounds of race, color, or national origin.  **Vendor/Provider**  **Signature X** | | | | | | | | | | | | | | | | | | | | **Instructions to receive payment:** Mail this signed "Voucher Copy," billing, and report of service (if requested) to local agency indicated at bottom. Medicaid and insurance must be billed prior to making claim to CSHCN. Payment will only be made upon receipt of documented proof of denial or amount of reimbursement from other payment sources. | | | | | | | | | | | | | | | | |
| 20. ACCOUNT CODE – FOR AGENCY USE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prepared By | | | | | | | | | Telephone Number | | | | | | | | Date | | | | | Agency Approval | | | | | | | | | | | Date | | | |
| Doc Date | | Pmt Due Date | | | | | | Current Doc No. | | | | | Ref. Doc. No. | | | | Vendor Number | | | | | | | Vendor Message | | | | | | Use Tax | | UBI Number | | | | |
|  |  | |  | | Master Index | | | | |  | | | | | | Workclass | | | County | | City/Town | | | |  | |  | |  | | |  | |  | | |
| REF DOC SUF | TRANS CODE | | MOD | | APPN INDEX | | PROGRAM INDEX | | | SUB OBJ | | SUB SUB OBJ | | | ORG INDEX | ALLOC | | | BUDGET UNIT | | MOS | | | | PROJECT | | SUB PROJ | | PROJ PHAS | | AMOUNT | | | | | INVOICE NUMBER |
|  |  | |  | |  | |  | | |  | |  | | |  |  | | |  | |  | | | |  | |  | |  | |  | | | | |  |
|  |  | |  | |  | |  | | |  | |  | | |  |  | | |  | |  | | | |  | |  | |  | |  | | | | |  |
|  |  | |  | |  | |  | | |  | |  | | |  |  | | |  | |  | | | |  | |  | |  | |  | | | | |  |
| Accounting Approval For Payment | | | | | | | | | | | | | | | Date | | | | | | | | | | Warrant Total | | | | | | | Warrant Number | | | | |
| 21. Return To: | | | | | | |  | | --- | |  | | | | | | | | | | | | | | | | | | | 22. Prepared By: | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| 23. Authorized By: | | | | | | | | | | | | |
| For people with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).  DOH-910-002 (Rev. 09/14) | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | |