

M.T.E. and Wagner v. DSHS
RECIPIENT CERTIFICATION OF PAYMENT(S)

I certify that I or my dependent(s)/ward(s) received Medicaid-funded personal care services while under the age of 18 years, between July 1, 2005 and November 30, 2011.

I certify that I or my dependent(s)/ward(s) received personal care services in excess of the amount authorized by the Department of Social and Health Services (DSHS), for which I paid out-of-pocket, as set forth on the claim form on the back of this page and any additional pages.

I certify that the information provided in this Claim Form is true and correct. I understand that the payment of my claim may involve federally funded Medicaid dollars.

I authorize Epiq Systems to obtain any necessary information from the Washington Department of Social and Health Services and/or the personal care providers identified on the attached claim form to confirm this certification.

Signature: _____ Date: _____

* * *

Type or Print Your Name (required): _____

Name of Person who received services (required): _____

Date of Birth of the person who received services (required): _____

You **must** include the following elements of proof with this claim form: (1) proof of uncovered personal care service dates (month/year); (2) identity of the personal care provider(s); and (3) proof of the unreimbursed charges. Please see the enclosed "Instructions for Claim Form" material under "Documentation" for a list of the type of documents that must be submitted to establish each element.

Current Address: _____
(Street or P.O. Box)

City, State and Zip Code

Daytime/Evening Telephone Numbers: _____ (day) _____ (eve.)

Please include your DSHS identification number: _____