REIMBURSEMENT OF MEDICAL EXPENSES.

Version 20210311, OHIP-0031 Form.

Local Districts complete the green cells.

Local District	Recipient Name	Recipient's SSN (Numbers Only)	Recipient's Medicaid Application Date mm-dd-yy	Eligibility Date From: mm-dd-yy	Eligibility Date To: mm-dd-yy	Recipient Street Address	Recipient City	Recipient State	Recipient Zip Code (5 digits)	CIN#	Representative Name	Representative Street Address	Representative City	Representative State	Representative Zip Code (5 digits)	Provider / Vendor Name	NPI or Provider ID (If Applicable)

Procedure Code (CPT) or Drug Code (NDC)	Description (for drugs, provide name and strength, place the quantity in next column)	Quantity	Date of Service mm-dd-yy	Home Care Provider Rate and Locator Code *(Rate Code - Locator Code)*	Amount Member Paid at Time of Service	Claim Category (Reason Code 1, 2, 3, or 4)	Case Type	Date This Form Was Completed mm-dd-yy	Worker Email	Comments (Optional)	Gray Cells for State Use Only: Category of Service (COS)	Unit Price	Dispensing Fee	Extended Price as Per Fee Schedule	Reimbursement Amount	Notes