



Home Care Ombudsman Payment Request

MFP Home Care Ombudsman (HCO) Services Rendered for:

Participant Name:	Participant/Contact Phone:
Participant Address:	Participant City /Zip /County

Home Care Ombudsman Complete:	
Participant Medicaid ID#:	Participant Date of Birth:
Discharge Date:	Anticipated MFP End Date:

PAYMENT INSTRUCTION

HCO Name:	HCO Phone:
MAIL CHECK TO (if different):	Tax ID, FEIN or SS#:
Address:	City/State/Zip

DESCRIPTION OF MFP HOME CARE OMBUDSMAN (HCO) SERVICES

Service Dates and Description	Billed Amount
Total Check Amount	

HC Ombudsman note: Check the appropriate box below to indicate how services were provided and documented -

- telephone call – contact must be documented in case notes, no participant signature required on this form
- in-person (face-to-face) – contact must be documented in case notes, participant signature required on this form

By signing this form, I attest that services were delivered/received consistent with the Individualized Transition Plan (ITP) or Person Centered Description and MFP Authorization for Services. I understand that Medicaid is the payer of last resort.

MFP Participant Signature **Date**

Home Care Ombudsman Signature **Date**

MFP Field Personnel (Print Name): _____

Phone: _____ Fax: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

HC Ombudsman note: send this completed form to MFP field personnel via fax or file transfer protocol (FTP).

MFP Field Personnel note: once verified, send this completed form to the Fiscal Intermediary by **FTP**. Send this completed form to DCH MFP office by **FTP**.