Date _____

H S & R REPORT REQUEST FORM*

Provider Name

_____

Medicaid Provider Number

_____

From Date of Service (DOS) _____

To Date of Service (DOS) _____

From Date of Payment (DOP) _____

To Date of Payment (DOP) _____

Type of Report _____ Summary ☐ Detail ☐

Medicaid ☐ Peachcare ☐

HS&R report to be received per _____ WEB ☐ CD ☐

Please note: Only enrolled Medicaid providers can receive requested HS&R reports per the web. All others will have to request per CD and will be accessed a fee as detailed below.

Requested By _____

Address _____

_____

Phone #: _____

NOTES:

Submit to: Hospitalunit@dch.ga.gov

Date Ordered

_____Date

Received_____ WEB 

CD

* Please advise of $30 charge for Summary and $200 charge for Detail to non-Medicaid providers