



Ombudsman Payment Request



MFP Ombudsman Services Rendered for:

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

| | |
|----------------------------------|-----------------------------------|
| MFP Ombudsman Complete: | |
| Participant Medicaid ID#: | Participant Date of Birth: |
| Discharge Date: | Anticipated MFP End Date: |

PAYMENT INSTRUCTION

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

DESCRIPTION OF MFP OMBUDSMAN SERVICES

| Service Dates and Description | Billed Amount |
|-------------------------------|---------------|
| | |
| | |
| | |
| Total Check Amount | |

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 Plans (ITPs) or Person Centered Description and MFP Authorization for Services. I understand that Medicaid is the payer of last resort.

MFP Participant Signature **Date**

Ombudsman Signature **Date**

MFP Field Personnel (Print Name): _____

Phone: _____ Fax: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

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**.