MEDICAL ASSISTANCE REIMBURSEMENT DETAIL FORM

_____Department of Social Services Recipient Name: _____

Case #:_____

BILLS SUBMITTED FOR PAYMENT			**REASON WE WILL NOT PAY OR WILL PAY ONLY PART OF BILL**			
DATE OF BILL	NAME OF PROVIDER DESCRIPTION OF SERVICE	AMOUNT OF BILL	MAXIMUM PAYABLE BY MEDICAL ASSISTANCE	TPHI SPENDDOWN AMOUNT	AMOUNT WE WILL PAY	OTHER: - Service Dates Not Covered - Ineligible Service - Missing Information - Etc.