SPECIALIZED CARE FOR CHILDREN

REIMBURSEMENT OF MEDICATIONS, MEDICAL CARE/CO-PAYMENTS

PAYEE'S SOCIAL SECURITY NUMBER
PAYEE'S NAME AND COMPLETE MAILING ADDRESS

CHILD'S NAME _____

DSCC CASE NUMBER _____

To receive reimbursement, this cost log including receipts must be returned to your Regional Office. Copies of drug receipts can be submitted if the original receipts were sent to the primary insurance company. UIC-DSCC will only pay for approved costs related to a child's UIC-DSCC medically-eligible condition.

DATE OF SERVICE (List in date order)	RX NUMBER (Prescription co-pay only)	PRESCRIBING PHYSICIAN or PROVIDER OF SERVICE	DESCRIPTION OF SERVICE or PRESCRIBED ITEM (Must be completed if no RX number)	AMOUNT PAID
		TOTAL REIMBURSEMENT		**$** 0.00

I certify the amount(s) above were paid to the identified provider for prescribed medications or medical service on behalf of the UIC-DSCC child.

PAYEE'S SIGNATURE DATE _____

DSCC USE ONLY

VERIFICATION OF PAYEE & ADDRESS:
Payment: FRA ☐ Spouse of FRA in same household ☐ Other ☐ (must be enrolled in CPS)

I approve the reimbursement for the above medication/medical services and that the services or medications were appropriate to treat the UIC-DSCC eligible condition. Payment is sent to the address of the FRA. Payment to another address requires enrollment of payee.

CARE COORDINATOR/PCA CERTIFICATION _____ DATE _____

RM/ARM APPROVAL _____ DATE _____

(For RO address stamp)

********See reverse side for detailed instructions********

WHAT YOU SHOULD DO TO BE REIMBURSED FOR MEDICATIONS AND CO-PAYS FOR MEDICAL SERVICES.

- Complete items 1-9 as described below.
- Sign and date the form.
- Send in original drug receipts and the insurance carrier's explanation of benefits (if applicable). Copies of drug receipts can be submitted if the original receipts were sent to the primary insurance company. Send receipt from provider for office visit or medical services. Send copy of physician's prescription to your Regional Office in addition to the original cash register receipt for items without an RX number.
- Please send this reimbursement form within **thirty (30) days** from date of service.
- If the payee living in the same household as the financially-responsible adult prefers to be reimbursed directly, the payee must be enrolled as a UIC-DSCC provider.

HOW TO COMPLETE THIS FORM:

1. **PAYEE'S SOCIAL SECURITY NUMBER, NAME AND MAILING ADDRESS:** Enter the Social Security Number, name and mailing address of the person to receive reimbursement.
2. **CHILD'S NAME AND CASE NUMBER:** Enter the child's legal name and the Division of Specialized Care for Children (DSCC) six digit case number.
3. **DATE OF SERVICE:** Write the date prescription was filled or the date medical services were provided (month-day-year). List in date order.
4. **RX NUMBER:** Write the prescription "RX" number from the drug receipt.
5. **PRESCRIBING PHYSICIAN or NAME OF PROVIDER:** For medication, write the name of the prescribing individual listed on drug ticket. If hospital is listed on drug receipt, include prescribing individual's name. For medical services, write the name of the physician who provided medical services.
6. **DESCRIPTION OF SERVICE or PRESCRIBED ITEM:** Identify and describe service or prescribed items. (This must be completed if item does not have an RX number.)
7. **AMOUNT PAID:** Write the amount you paid for the medication, other prescribed item, or medical services.
8. **TOTAL REIMBURSEMENT:** Write the total of all amounts paid.
9. **PAYEE'S SIGNATURE AND DATE:** Signature of the person whose Social Security Number (payee) is listed at top of form and who will receive reimbursement. Enter the date the Cost Log was signed.
10. **CARE COORDINATOR/PCA CERTIFICATION: Don't write in this space**. (To be signed by UIC-DSCC Care Coordinator.)
11. **RM/ARM CERTIFICATION: Don't write in this space**. (To be signed by the Manager.)

BEFORE SENDING HAVE YOU . . .

- Attached the original drug receipt, pharmacy print-out or co-pay receipt from provider for medical services?
- Attached the itemized cash register receipt for over the counter item/service and a description.
- Attached the insurance carrier's explanation of benefits?
- Completed the front side of form including signing and dating the form?

MAIL TO:

Address in lower left corner on front of this form.

NEED HELP WITH THIS FORM?

Call your Care Coordinator using the Regional Office's toll free number.