State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

ADMINISTRATIVE OFFICES
QUAKERBRIDGE PLAZA—BUILDING 5 & 7 & 12
QUAKERBRIDGE ROAD
TRENTON, NEW JERSEY 08619

ADDRESS REPLY TO:
CN-712
TRENTON, NEW JERSEY 08625

MEDICAID COMMUNICATION 87-9 DATE: March 24, 1987

TO: County Welfare Agency Directors

SUBJECT: Reimbursement for Distribution of Medicaid-ID Cards

Attached is a copy of the format which the County Welfare Agencies can reproduce to use when requesting payment of the costs incurred in the distribution of Medicaid-ID cards. The information requested on the form is self-explanatory. However, the Medicaid Communication 87-3, dated February 5, 1987, can be referred to for more details.

The form must be received by this Division by the 20th of each month following the month being reported. If not, the request for payment will be processed in the following month. The form should be mailed to:

Ronald J. Kavas, Assistant Director
Administrative and Fiscal Affairs
Division of Medical Assistance
and Health Services
CN 712
Trenton, New Jersey 08625

Your assistance in distributing the Medicaid-ID cards is appreciated.

Sincerely yours,

Thomas M. Russo, Director
Division of Medical Assistance
and Health Services

TMR:Sn
attachment
cc: Odella T. Welch
Deputy Commissioner

Marion Reitz, Acting Director
Division of Public Welfare

Thomas Blatner, Director
Division of Youth and Family Services Management Team

REQUEST FOR REIMBURSEMENT FORM *

MEDICAID - ID CARDS

County Name: _____

For the Month Ending: _____

Distribution:

_____	Insert @ .05	$	_____
_____	Separate Mail @ .25	$	_____
Total Cost:		$	==========

Form Completed By:

Name _____ _____
(Print) Phone Number

Title _____

Certified By:

I, _____, certify that the
Print Name/Title
information as reported is accurate and supported by manual/automated statistical records.

_____
Signature Date

* For additional information see Medical Communication 87-3 dated February 5, 1987.