Morrow County Job & Family Services

619 W. Marion Road
Mount Gilead, Ohio 43338
419-947-9111
419-947-9115 Fax

NET Verification Form

To Be Completed by Medical Provider
ONE FORM PER PROVIDER

Agency Use

_____
Case Number

NOTE: Appointment **must** be a Medicaid billable service

_____
Medical Facility Name

_____
Medical Provider / Doctor Name

_____
Medical Provider Address

_____
City, State, Zip

_____
Phone

Appointment/ER Visit Information

_____ had an office visit
Patient's Name-**PLEASE PRINT**

Was the service provided covered under the Medicaid Program? YES NO
(Must be answered)

Was the service provided for a Workers Compensation or Social Security Claim? YES NO
(Must be answered)

Date: Appt Time: *Medical Provider Signature

_____ _____ _____

Visit ***MUST be signed by a medical provider to receive reimbursement***

Consumer Information

_____ _____
Patient Name – Please Print Client Contact #

_____ _____
Patient or Parent/Guardian (if patient is a minor) Signature Patient's Social Security Number

This form MUST be returned within TEN (10) business days
of the appointment to receive reimbursement.