

Charles County Human Services Partnership

PAYMENT REQUEST FOR MEDICAID INELIGIBLE CONSUMERS

Date of Request _____

Requesting Agency _____ Tele: _____

Client Name _____ SSN: _____ DOB: _____

Has client received assistance in the past? No__ Yes__ Date of request: __/__/__

I hereby certify that

- The client has no prescription coverage of any kind
- The client has applied for Maryland Pharmacy Assistance Program - Date applied: __/__/__
- The prescribing physician cannot provide samples
- These medications are not available through pharmaceutical manufacturer/seller's client assistance
- No other sources of payment are known

Prescription Details

1. _____
2. _____
3. _____
4. _____

Prescribing Physician's Signature: _____

Payment Information

- a) Estimated Total cost \$ _____
- b) Co-pay Amount \$ _____
- c) Other Payment \$ _____
- CCHSP Request \$ _____

Pharmacy Information

- _____ CVS - La Plata Attn: Sean Hopper
(Tele 301-934-9564 Fax 301-934-8765)
- _____ Anchor Pharmacy - Waldorf
(Tele 301-932-4200 Fax 301-932-9477)

***Prescriptions will be picked up by client or case manager**

Signature of Certifying Official/Case Manager: _____

CCHSP ACTION TAKEN:

Request Approved _____

Request Denied _____

Amount Approved _____

Signature of CCHSP Official

Date