

# Morrow County Job & Family Services

619 W. Marion Rd.  
Mt. Gilead, Ohio 43338  
419-947-9111  
419-947-9115 FAX

## NET Verification Form

<b>To Be Completed by Medical Provider</b> ***ONE FORM PER PROVIDER***	<b>Agency Use</b>
<p>***NOTE: <u>Appointment must be a Medicaid billable service</u>***</p> <p>_____</p> <p>Medical Provider Name</p> <p>_____</p> <p>Medical Provider Address</p> <p>_____</p> <p>City, State, Zip</p> <p>_____</p> <p>Office Phone Number</p>	<p>_____</p> <p>Case Number</p>
<h3><u>Appointment/ ER Visit Information</u></h3> <p>_____ had an office visit</p> <p>Patient's Name- PLEASE PRINT</p> <p>Was the service provided covered under the Medicaid program? YES NO</p> <p>Was the service provided for a Workers Compensation or Social Security claim? YES NO</p> <p>Date: _____ Appt Time: _____ * Medical Provider Signature: _____</p> <p>_____</p> <p>***Visit <b>MUST</b> be signed by a medical provider to receive reimbursement**</p>	
<h3><u>Consumer Information</u></h3> <p>_____</p> <p>Patient Name – Please Print Billing or MMIS #</p> <p>_____</p> <p>Patient or Parent/Guardian (if patient is a minor) Signature Patient's Social Security Number</p>	

**This form MUST be returned within five (5) business days of the appointment to receive reimbursement.**