MEDICAID DISABILITY
INITIAL REQUEST TO PROVIDER FOR RECORDS
State Form 52479 (12-05) / FI 2322

DATE:

Provider Name	**Case Number**	Caseworker ID	Telephone
Address	FAX	E-mail	
	County Office		

Dear Provider:

This request is made on behalf of the individual below who has applied for Medicaid Disability:

Name of Applicant	Last 4 digits of SSN XXX-XX-	Date of Birth

This individual has listed you as providing medical services to him/her at some point during the past twelve months.

I am requesting that you send the following information: _____

_____

_____

This information is necessary in order to determine the individual's eligibility for Medicaid.

I would appreciate your sending the requested information to me no later than_____ (20 days from the date of this request) to the address listed at the top of this letter:

If you have a concern regarding this request, please contact me right away. My contact information is at the top of this letter.

THANK YOU VERY MUCH FOR YOUR ASSISTANCE.

_____. Caseworker