FORM NUMBER
24-06-13

ATTACHMENT INDICATOR

GENERAL MEDICAL SERVICE

☐ MEDICAL SUPPLIES

☐ NON EMERGENCY MEDICAL TRANSPORTATION

UTAH DEPARTMENT OF HEALTH
MEDICAID FORM

DOCUMENT NUMBER
01234567

LINE NO.	1. CLIENT NAME LAST	FIRST	M.I.	2. CLIENT IDENTIFICATION NUMBER	3. ORG. P.O.S	4. DEST	5. MILES	6. EXTRA CHARGE	7. PRIOR AUTHORIZATION NUMBER	8. DATE OF SERVICE MM/DD/YY	9. ITEM CODE	10. ITEM DESCRIPTION	11. QTY	12. CHARGE	13. LESS OTHER SOURCES	STATE USE ONLY
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14. REMARKS
LINE
LINE
LINE

15. PROVIDER NAME & ADDRESS

16. PROVIDER NUMBER

17. BILLING DATE
MM DD YY

18. PROVIDER SIGNATURE (This is to certify that the information provided above is true, accurate, and complete. I have read, understand, and agree to the conditions set forth in the certification statement on the reverse side of this form.)

PROVIDER CERTIFICATION AGREEMENT:

By placing my signature in the provider signature box on the reverse side of this claim form, I certify the following for each claim I am making:

1. That I will keep such records for a minimum for five (5) years as are necessary to fully disclose the extent of services listed for each claim which were provided to individuals under Utah's Title XIX plan. I will make such records available to agents of the State and Federal Title XIX agencies, including the State Medicaid Fraud Control Unit, upon request.

2. That I understand that payment and satisfaction for each claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal and State Laws.