Children and Youth with Special Health Care Needs (CYSHCN)

HEALTH SERVICES AUTHORIZATION

Asterisk (*) = Required Data for Payment

AUTHORIZATION NO.

1. PATIENT*:

2. PROVIDERONE (P1) ID*

3. CHIF ID (if P1 not available)

4. ADDRESS:

5. DIAGNOSIS*:

10. BIRTH YEAR*

11. COUNTY OF RESIDENCE & CODE*

6. VENDOR OR PROVIDER*

RETURN AUTHORIZATION BY

12. AUTHORIZATION DATE*

13. AUTHORIZATION EXPIRES*

7. VENDOR/PROVIDER FEDERAL TAX ID NO.*	8. VENDOR/PROVIDER NPI	9. VENDOR/PROVIDER TAXONOMY	14. INSURANCE/POLICY NO./NAME*

You are authorized to perform the following services for which CSHCN will be obligated to pay their fee, according to currently established payment policy or fee schedule. For payment questions and additional services not specified nor ordinarily included as a part of the description, contact local agency indicated at bottom.

15. CPT/HCPCS/DOH*	16. DESCRIPTION/DATE(S) OF SERVICE(S)*	17. AMOUNT AUTHORIZED	18. FOR AGENCY USE
	DESCRIPTION: BEGIN DATE OF SERVICE(S) END DATE OF SERVICE(S)		

Vendor/Provider of Service agrees to accept CSHCN fee as payment in full and that no additional charge will be made to the patient or his/her family for these services.

19. I certify that all services represented by this voucher have been provided without discrimination on the grounds of race, color, or national origin.

VENDOR/PROVIDER SIGNATURE X

Instructions to receive payment: Mail this signed "Voucher Copy," billing, and report of service (if requested) to local agency indicated at bottom. Medicaid and insurance must be billed prior to making claim to CSHCN. Payment will only be made upon receipt of documented proof of denial or amount of reimbursement from other payment sources.

20. ACCOUNT CODE – FOR AGENCY USE

PREPARED BY	TELEPHONE NUMBER	DATE	AGENCY APPROVAL	DATE

DOC DATE	PMT DUE DATE	CURRENT DOC NO.	REF. DOC. NO.	VENDOR NUMBER	VENDOR MESSAGE	USE TAX	UBI NUMBER

			MASTER INDEX					WORKCLASS	COUNTY	CITY/TOWN					
REF DOC SUF	TRANS CODE	MOD	APPN INDEX	PROGRAM INDEX	SUB OBJ	SUB SUB OBJ	ORG INDEX	ALLOC	BUDGET UNIT	MOS	PROJECT	SUB PROJ	PROJ PHAS	AMOUNT	INVOICE NUMBER

ACCOUNTING APPROVAL FOR PAYMENT	DATE	WARRANT TOTAL	WARRANT NUMBER

21. RETURN TO:

22. PREPARED BY:

23. AUTHORIZED BY:

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.