

UMCHS - REQUEST FOR MEDICAL/DENTAL SERVICES PAY VOUCHER

Dental Exam
 Dental Treatment

Well Child Exam
 Medical Treatment

Student's Name: _____ **Head Start Classroom:** _____

Parent/Guardian's Name: _____ **Contact Telephone:** _____

Health Care Provider: _____ **Appointment Date and Time:** _____

HCP Telephone: _____ **HCP Fax:** _____

Requesting staff name: _____

The following information **MUST** be provided by UMCHS staff assisting parent with establishing a medical payer for Well Child and dental exams and treatment:

Child's Country of Birth: _____ **DOB:** _____

Yes **No**

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Child is covered by private insurance for Well Child care. |
| <input type="checkbox"/> | <input type="checkbox"/> | Family has applied for Well Child preventive care through OHP (Only required if child was born in the United States.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Child is eligible for Well Child preventive care through OHP.
If No, explain why: _____
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <u>For children born in the United States</u> , a copy of OHP Eligibility Verification Letter from the Department of Human Services is attached. |
| <input type="checkbox"/> | <input type="checkbox"/> | <u>For children born outside of the United States</u> , a copy of the child's birth certificate is attached. |
| <input type="checkbox"/> | <input type="checkbox"/> | Child's health care provider or other community resource is willing to donate services. |

Head Start is the payer of last resort; only children with above documentation will be considered for financial aid through UMCHS.

I attest that the above information is truthful and accurate to the best of my knowledge:

Staff Signature: _____ **Date:** _____

UMATILLA-MORROW COUNTY HEAD START, INC.
110 NE 4TH Street, Hermiston, OR 98438
(541) 564-6878 tel., (541) 564-6879 fax

UMCHS - MEDICAL AND DENTAL SERVICES PAY VOUCHER

Student's Name: _____ **DOB:** _____

Parent/Guardian's Name: _____ **Contact Phone:** _____

Head Start Classroom: _____ **School Phone:** _____

Health Care Provider: _____ **Provider Phone:** _____

Parent will call for date and appointment time. Voucher Faxed _____

UMCHS authorizes payment to provider listed above for the following service appointment:

- | | |
|---|---|
| <input type="checkbox"/> Well Child Exam*(\$25.00) | <input type="checkbox"/> Medical Treatment/Follow-Up |
| <input type="checkbox"/> Dental Exam**(\$37.44) | <input type="checkbox"/> Dental Treatment/Follow-Up |
| <input type="checkbox"/> Other Medical: _____ | |

*For reimbursement purposes, Well Child Exams entail a health history and head to toe unclothed physical only. Lab work of any kind will not be reimbursed as part of a Well Child Exam without preauthorization from Health Services Director. If the provider has concerns about child's nutritional status, a referral can be made to WIC. Immunizations are offered at our local health departments. It is our hope that families utilizing Head Start Pay Vouchers will not be billed for any portion of the exam.

** At this time dental cleanings will only be covered for children with 5 or more teeth with cavities. For a Dental Fee Schedule detailing reimbursement rates and covered procedures, please contact Health Services Director.

Voucher valid for service identified above. *Voucher valid through May 31st, Billing received after May, may not receive payment due to Head Start budget/funding cycle.*

The following UMCHS staff are available for contact to assist with service coordination with family if needed:

Family Services: _____ **Phone:** _____ **Fax:** _____
Health Services Director : _____ **Phone:** _____ **Fax:** _____

Please send copy of exam record and any associated chart notes for this appointment along with billing statement to the UMCHS, Health Services Director.

All payment for medical or dental services is based upon UMCHS Fee Schedule or established contractual agreement rates.

Additional vouchers are required for subsequent appointments and must also be pre-authorized by the UMCHS, Health Services Director.

Billing estimates are required for prior-authorization for any additional treatment/care appointments. Please send billing estimates for recommended follow-up care to the HSD at the address listed :

Attention: Health Services Director
Umatilla Morrow Head Start
110 NE 4th Street
Hermiston ,OR 97838

Voucher Authorized by: _____ **Date:** _____
(Health Services Director)