Medical/Dental Payment Requisition

Date of Request _____/_____/_____

Staff completing requisition _____

Child's Name _____

Center _____

Insurance Information

Does the family have medical insurance? [ ] Yes [ ] No

If yes,
Provider/Company _____

ID Number _____

If the family has no insurance, please list information regarding application for insurance _____

_____

_____

Medical/Dental Provider _____

Address _____

_____

Phone ( ) _____-_____

Scheduled Appt Date _____/_____/_____

Services to be Provided _____

_____

Estimated cost of services $_____

List attempts to locate additional resources for services _____

_____

_____

By signing this section, you are stating that you have exhausted all other resources for payment of this child's services in accordance with Performance Standard 1304.20(c)5.

_____ _____/_____/_____
Signature Date

Authorization

_____ _____/_____/_____
Health Manager Date

Are funds available?
[ ] Yes [ ] No

Charge to:
[ ] Head Start Funds
[ ] Early Head Start Funds
[ ] State Funds

[ ] Approved
[ ] Denied

_____ _____/____/_____
Comptroller Date

_____ _____/_____/_____
Purchasing Agent Date