FLORIDA MEDICAID DIRECT REIMBURSEMENT
PROVIDER INFORMATION REQUEST

To: _____ Date: _____

_____

_____

Florida Medicaid reimburses recipients who have paid for medical goods or service(s) that would otherwise have been covered by Florida Medicaid in accordance with Rule 59G-5.110, Florida Administrative Code.

The recipient listed below has requested reimbursement for medical goods or services you provided from _____ to _____.

Recipient's Name:_____

Medicaid Identification Number:_____

In order for the Agency for Health Care Administration to determine whether the recipient is eligible to be reimbursed, complete the information listed below and email the completed form to direct_reimbursement@ahca.myflorida.com. For those that do not have internet access, the form may be returned to the following address:

Agency for Health Care Administration
2727 Mahan Drive
MS# 58
Tallahassee, FL 32308
ATTN: Direct Reimbursement

DATE OF SERVICE	PROCEDURE OR NATIONAL DRUG CODE	DIAGNOSIS CODE	UNITS OF SERVICE	AMOUNT PAID BY RECIPIENT	DATE PAID BY RECIPIENT

_____ _____
Provider Name (print) Date

_____ _____
Authorized Provider Signature Phone Number