Patient Liability Reconciliation Form

Submit to: MyCareOHClaims@CENTENE.com
To comply with HIPAA, you must use secure email.

Facility Name: ______________________ Facility NPI: ______________________

Facility Medicaid Number: ______________________ Contact Person: ______________________

Email: ______________________ Date: ______________________

Claim Number	Resubmission (9401 previously submitted)	Last Name	First Name	Health Plan Member ID	Patient's Medicaid Number	Patient Liability Deducted from Paid Claim	Actual Patient Liability	Documents Attached
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You must attach documentation of patient/client liability (for example, screen shot from MITS) for each claim listed above. Please use a separate form for each MyCare Ohio health plan.

MyCareOhio
Connecting Medicare + Medicaid