Job Family Services
Allen County

Medical Provider Verification Form

This confirms that _____ was seen in our office on _____ during _____ timeframe.

Patients next appointment with _____ on _____ at _____.

☐ We are a Medicaid provider and the service provided was a Medicaid covered service.

Purpose of Visit (or Medicaid Program):
Medicaid Provider Representative Name (Printed)
Medicaid Provider Representative Signature
Date

Medicaid Provider's Name, address & phone number (an address stamp with this information may also be used).

If you have questions, please call the Social Services Supervisor at (419) 999-0291.

RETURN TO: FAX: (419) 228-0420 or **Email:** allen_social_services@jfs.ohio.gov

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