

Self-Directed Services - Goods and Services Expense Form

Oklahoma Health Care Authority

Long Term Care Administration

Participant Name				
	<i>Last</i>	<i>First</i>	<i>M.I.</i>	<i>SoonerCare ID</i>

***Please check one:**

- I have paid for this approved good or service and requesting reimbursement.
(Must attach receipt or proof of payment with \$ amount.)
- I have not paid for this good or service and requesting Morning Star to pay directly.
(Must attach estimate or bill with \$ amount.)

***Make check payable to:** _____

***Mail Check to:** _____

Address: _____ Phone #: _____

Social Security or Federal ID number (if applicable): _____
(For use on 1099 if necessary)

*Description of Goods/Services	Date	Amount (\$)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Total Amount Due:		_____

***Specific Instructions/Comments:**

*** Member/Employer's Signature:** _____

For OHCA Approval mail or fax to: Attn:
Long Term Care Administration
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Fax: 405-530-7265
Phone: 888-287-2443