FOR-PROFIT MEDICAID PAYMENT SUMMARY

Name: _____ Number (PO…) _____

Site Name: _____ Month/Year: _____

Total Enrollment (on the last day of month): _____

Copies of Medicaid payment documentation must be on file for each participant listed below.

Names of Enrolled Participants Receiving Medicaid Payments for the Month:	Check if Medicaid Payment Documentation is on file	Comments:
1.		
2.		
3.		
4.		
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25.		

Copies of Medicaid payment documentation must be on file for each participant listed below.

Names of Enrolled Participants Receiving Medicaid Payments for the Month:	Check if Medicaid Payment Documentation is on file	Comments:
26.		
27.		
28.		
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