

DIVISION OF MATERNAL AND CHILD HEALTH

Authorization for Services

- 1. Vendor Name: _____
- 2. Vendor Address: _____ Vendor Tax ID #: _____
_____ Phone Number: _____
- 3. Name of Patient: _____ 4. Birth Date: _____
- 5. Patient's Address: _____ 6. County of Residence: _____
_____ 7. Clinic Location: _____
- 8. Name of Parents or Guardian, if applicable: _____
- 9. Diagnosis: _____
- 10. Type of Service (check one): Physician Services Other (specify) _____
Metabolic formula Metabolic food products

11a. Specify Services Requested: _____ Itemized Charges: _____

11b. Invoice # _____ 12. TOTAL \$ _____

- 13. _____ 14. _____
P.O.E./Agency Personnel Date of Service(s)
Requesting Service(s)
- 15. _____ 16. _____
Patient or Responsible Party Date Received
Receiving Service(s) (Signature)
- 17. _____ 18. _____
Vendor (Signature) / Providing Service(s) Date of Service(s)

Please submit **ORIGINAL** to: Division of Maternal and Child Health
275 East Main Street, HS2W-C
Frankfort, Kentucky 40621-0001

Attention: KY Metabolic Foods & Formula Program
Phone: 502-564-2154
Fax: (502) 564-1510

STATE AGENCY USE ONLY Expenditures Authorized	
Amount \$ _____	Date: _____
Authorized By: _____	