Payment Request
Idaho Home Choice Money Follows the Person
Transition Services

Transition Services Rendered for:

Participant Name	Participant Phone Number
Participant Address	Participant City, State, Zip

Transition Manager Use Only	
Participant MID#:	Participant DOB:

Vendor Information

Vendor Name	Vendor Tax ID, EIN, or SS#	Vendor Phone #
Vendor Address	Vendor City, State, Zip	

Date	Service	Amount Billed
Total Amount Billed		

By signing this form, I attest that Transition Services were delivered and received consistent with the Participant's Transition Plan and the Idaho Home Choice Money Follows the Person Program and that appropriate back-up documentation has been submitted. I understand that Medicaid is the payer of last resort.

Participant or Guardian Signature: _____ **Date** _____

Vendor Signature: _____ **Date** _____

Please attach all receipts and supportive documentation with form to:

Idaho Home Choice
3232 Elder Street
Boise, ID 83705

Fax: (208)332-7283
Email: IHCMFP@dhw.idaho.gov