Appendix R

ITEMIZED PAID CLAIMS

(County Form Used to Provide Supporting Reimbursement Information to Hospitals)

HOSPITAL NAME: ____ DATE: __________________

HOSPITAL # ______________________________ COUNTY: _________________________________

LAST, FIRST MI NAME	SOCIAL SECURITY NUMBER	ADMIT DATE	PAID # OF DAYS	AMOUNT PAID
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				