

STATE MATCH VERIFICATION SIGNATURE TRANSMITTAL		
	DATE OF SERVICE RANGE:	
# OF CLAIM LINES		
# OF INVOICES		
# OF UNITS OF SERVICE		
REIMBURSEMENT RATE	\$	
STATE PORTION OF RATE	\$	
STATE FUNDS CLAIMED		\$

The attached State Match Verification claims are itemized by consumer, by service, and correspond directly with Medical Assistance invoicing for the same time period. I have authorized payment in state funds to support the identified services and encourage the provider to seek federal reimbursement for the identified services by invoicing the Medical Assistance program.

County Administrator

Date