State of Illinois
Department of Human Services - Bureau of Maternal and Child Health

PEDIATRIC PRIMARY CARE MONTHLY CLAIM FORM

Agency Name: _____

FEIN: _____ Dates: _____ through: _____

IDHS Agreement No.: _____

CLIENT ID NUMBER	CPT/PROCEDURE SERVICE CODE	REIMBURSEMENT RATE
	TOTAL:	

_____**Number of New Prenatal Clients (unduplicated)**

_____**Number of New Pediatric Clients (unduplicated)**

Certification:
I hereby certify that the goods and/or services claimed above are necessary expenditures for the program and are a part of the approved budged, that appropriate purchasing procedures have been followed and that payment has not previously been requested or received.

Authorized Agency Official

Name: _____

Title: _____

Date: _____

Signature: _____