Premier
Financial Management Services

PARTICIPANT CHECK REQUEST FORM

Instructions: *Form is to be filled out by Participant/Guardian **ONLY**. Attach a **copy of the receipt or documentation** of when the service was provided. Please sign and date at the bottom and submit the completed form to **Premier Financial Management Services** via one of the following options below:*

MAIL:
PO Box 26001
Milwaukee, WI 53226

DROP OFF:
10425 W North Ave.
Suite 345
Milwaukee, WI 53226

EMAIL:
claims@premier-fms.com

FAX:
1-888-859-6472

Participant Information:

Name: _____ Last 4 Digits of SSN: _____

Make check payable to:

Name: _____

Address: _____

City/State/Zip: _____

☐ Check this box **ONLY** if you **DO NOT** want check to be mailed to vendor.

DATE OF INVOICE	SERVICE CODE	DESCRIPTION OF SERVICE	UNIT	QUANTITY	RATE	AMOUNT

REMINDER: Please attach a copy of the receipt, invoice, or other documentation confirming the amount of purchase.

By signing this form, I approve Premier Financial Management Services to issue payment directly to me or the vendor above. I certify that the service(s) provided are in accordance with my budget. All information herein is true to the best of my knowledge and I understand that if it was falsified the payment will be considered Medicaid fraud and may result in dismissal from the program and/or criminal prosecution.

Print Name: _____

Signature: _____ Date: ____/____/_____