TEXAS Department of State Health Services

Form 113

COUNTY INDIGENT HEALTH CARE PROGRAM (CIHCP)
APPELLANT/PROVIDER ASSIGNMENT – CESIÓN DEL APELANTE Y DEL PROVEEDOR

County	Telephone No.	Case Number

APPELLANT ASSIGNMENT/CESION DEL SOLICITANTE DE SSI

I certify that I am currently appealing the Social Security denial decision. As a condition of receiving CIHCP health care services, I give the above-named county my rights to recover the cost of health care services provided by the county from any third party, up to the amount of expenditures made on my behalf by the county.

Certifico que estoy apelando la decisión del Seguro Social. Como condición de recibir los beneficios de salud de CIHCP, cedo al condado nombrado arriba mi derecho a recobrar de cualquier tercera agencia o persona, el costo de servicios de salud provistos por el condado hasta cubrir los gastos incurridos por el condado o por TDH en beneficio mío.

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Signature – Appellant/Firma – Solicitante de SSI | **Date**/Fecha

Name of Appellant/Nombre del Solicitante de SSI	Address (Street, City, State, ZIP)/**Dirección (Calle, Ciudad, Estado, ZIP)**

PROVIDER ASSIGNMENT

By signing this form, I agree to assign to the county my Medicaid reimbursement rights for services provided to this person and paid for by the county. I will not file claims with Medicaid for reimbursement of the county's payments.

In accepting this assignment, I agree to meet the following conditions:

- All claims I submit to the county must comply with all claims processing requirements for the Texas Medicaid Program. The claim forms will be imprinted in boldface type with the following statements:
  1. "This is to certify that the foregoing information is true, accurate, and complete."
  2. "I understand that ultimate payment of this claim may be from Federal and State funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws."

  The statements may be printed above my signature or, if printed on the reverse of the form, a reference to the statements must appear immediately preceding my signature.
- Any costs for processing claims as a result of this assignment will not be passed along to the county.
- I accept the amount paid by the county as payment in full for all services provided to the above-named appellant and I will not seek reimbursement for any difference between the amount paid by the county and the original billed amount from any person or entity.

THIS ASSIGNMENT IS NULL AND VOID IF THE APPELLANT DOES NOT BECOME SSI MEDICAID ELIGIBLE.

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Signature – Provider | **Date**

Provider's Name	National Provider Identifier (NPI, the 10-character Medicaid Billing ID #)	Telephone No.
		( )
Physical Address (Street, City, State, ZIP)		