MyCare Ohio
Patient/Client Liability Reconciliation

Health Plan (check one) **Date** _____

Aetna ___
Buckeye ___
CareSource ___
Molina ___
United ___

Facility Name _____ **Facility NPI** _____ **Facility Medicaid #** _____

Contact Person _____ **Email** _____

You must attach documentation of patient/client liability (for example, 9401, notice from AAA) for each claim listed below.
Please use a separate form for each MyCare Ohio health plan.

Claim # *(Optional)*	**Check if Resubmission** *(9401 previously submitted)*	**Last Name**	**First Name**	**Health Plan Member ID** *(Aetna, CareSource, United only)*	**Patient's Medicaid #**	**Patient Liability Deducted from Paid Claim**	**Actual Patient Liability** *(supported by attached documentation)*