General Assistance Medical Program

Title 19 Write-Off Requests

Name:	Phone:
Date:	Provider Name:
Invoice No.:	Provider No.: (Tax ID)

Please write-off $ _____ due to the following: (Check or Mark Applicable)

Title 19 Denial (Attach denial/remittance form from T19)
Family Planning Waiver (Attach documentation)
Amount on Claim Duplicated
Unable to Find Record / Not Our Patient
Unable to Access Record – Change in Billing Company (Provide letter)
Paid Wrong Provider
Services Not Rendered
Other Reason (Be specific)

*** Please provide backup documentation to support this request. ***

Fax form to (414)289-8534 ATTN: Sandra Williams____ Telephone #(414)289-6251