Provider Billing Issue

Request for Assistance

Agency on Aging
OF SOUTH CENTRAL CONNECTICUT
Your Advocate for Independence®

Date: _____

Agency Name: _____

Contact Name: _____

Email: _____ **Phone #:** _____

Reason for contact: Please Select

Client Name:		**Medicaid Id:**	
Service Type (Code)	**Date(s) of Service**	**Frequency**	**Funding Source**

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Additional Information:

Please submit encrypted to providers@aoascc.org or fax to 866-644-1929.

Reminder: protecting confidential client data with email encryption is the responsibility of the sender.