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Illinois Court of Claims

Office of the Secretary of State
630 S. College St., Springfield, IL 62756

(Complete four copies)

Medical Vendors Form

IN THE COURT OF CLAIMS, STATE OF ILLINOIS

_____	)
Claimant	)
	)
vs.	)
	)
Respondent,	)
STATE OF ILLINOIS	)

Claimant seeks from Respondent payment in the sum of $ _____ for _____ rendered by Claimant to persons eligible for Medical Assistance under programs
Type Medical Service
administered by the Illinois Department of Healthcare and Family Services *(hereinafter the Department).* The names of said persons, their Recipient identification numbers as assigned by the Department, the Case names and Case identification numbers assigned by the Department to the persons' family units, the dates of the services, which are the subject of this claim, the amounts invoiced to the Department for such services, the dates and sequence of Claimant's invoices to the Department, and the actions of the Department in response to those invoices *(and the dates of such actions)*, are itemized in Exhibit "A" *(Claimant's Bill of Particulars of the accounts for which Claimant seeks payment)*, hereto attached.

For each service, person and amount identified in Exhibit "A" Claimant has presented claims to the Department by form invoices listed in Exhibit "A," copies of which invoices are attached as Exhibit "B." For each claim itemized in Exhibit "A" payment was disallowed by the Department:

_____ (1) in documents designated by the voucher numbers stated in Exhibit "A," a copy of each such voucher being attached hereto as Exhibit "C," or

_____ (2) by other response, as detailed by Claimant in Exhibit "A."

Exhibits "A," "B" and "C" are made a part of this Complaint.

Claimant is enrolled as a participant in the Department's Medical Assistance Program, and has complied with the Department's requirements and regulations, as applicable to the subject medical services.

Claimant further states that no assignment of said claim, or any part thereof, or any interest therein, has been made to any person, and that Claimant is justly entitled to payment of the same from Respondent after allowing all just credits.

_____
Claimant's Signature

Ref: Section 11-13, Chpt. 23,
Ill. Revised Statutes as amended.
IDPA Medical-Service provider *(Vendor)*

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Claimant		Claimant's Attorney	
Street Address		Street Address	
City	State	City	State
ZIP	Telephone Number	ZIP	Telephone Number

or

Exhibit A

BILL OF PARTICULARS

Claimant *(Provider)* Name	Provider Reference (*PR)* No. *(assigned by Provider)*
Court of Claims Docket No.	Dates of Service *(DOS)*
Patient Name	Provider Billings & IDPA Responses
Patient Date of Birth *(DOB)*	PR #
IDPA Recipient No. *(RIN)*	DOS
(IDPA Case Name/Case No.)	Amount Billed to IDPA