I, _____, certify that the attached invoiced amounts represent co-pays that my practice did not collect for dates of service on August 25, 2017, through November 30, 2017, for CHIP members with a permanent address in one of the Hurricane Harvey FEMA-declared disaster counties,[1] in accordance with direction from Texas Health and Human Services.

The above and the attached are true and correct to the best of my knowledge and belief. I know that I may be subject to penalties if I provide false or untrue information. All original documents will be retained and preserved as required by law, and such documents will be submitted, or access to such documents permitted, as required by HHSC or any agency of the state or federal government, or their representative(s).

_____ _____

Signature Date

[1] A list of FEMA-declared disaster counties is available at: www.fema.gov/disaster/4332

Envolve Vision
CHIP Invoice Reimbursement Request

Envolve Vision
P.O. Box 7548
Rocky Mount, NC 27804

Date:

Provider Office Name:	
Provider Office Address:	
Provider Office Phone:	

Claim Number	Amount of Copayment

Total Amount:	$ 0.00

Reminder: All requests for copayment reimbursement for CHIP members, must be received by May 1, 2018