



Request to Change Contract Maximum Reimbursement Amount

Contract #:	Date:
Agency Name:	
Contact Person:	
Email Address:	
Current Contract Maximum: \$	Contract Maximum Requested: \$
Age/Disability(ies) Served:	Expenditures to date in FY10: \$
Billed to Medicaid FY10: \$	Billed to IPRS FY10: \$
Medicaid Claims Paid in FY10: \$	IPRS Claims Paid in FY10: \$
<p><i>Please describe the current services provided and include justification for any requested change in contract maximum reimbursable amount.</i></p> <p><i>Attach any fiscal and/or service data reports relevant to this request.</i></p>	
Additional Information:	

Signature of Legally Responsible Representative

Date

Please complete and submit to Melissa Faulkner at faul0852@westernhighlands.org.
Your request will be routed for approval and you will be promptly notified of the status via the email address you provided above.