Quality Care Services, Inc.

229 North Main Street, El Dorado, Kansas 67042

Email: qltyser@sbcglobal.net Website: www.qualitycarecacfp.com

Phone: (316) 321-7237
Toll Free (800) 273-1341
Fax: (316) 321-7237

AUTHORIZATION FOR ONLINE CLAIM REPORTING

Name of Provider

Street Address City St. Zip Code

E-mail Address

I certify that the information submitted online is true and correct to the best of my knowledge. I understand this information is being given in connection with the receipt of Federal funds and deliberate misrepresentation may subject me to prosecution under applicable state and federal criminal statutes.

Signature of Provider Date

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Staff Signature: __________________________________