

## Request for Non-Covered Services

To: Office of Eligibility Services  
Department of Health and Mental Hygiene  
201 West Preston St, Room SS-10  
Baltimore, Maryland 21201-2399

From: \_\_\_\_\_ County Department of Social Services

\_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_

---

Please include the following information:

Case Manager \_\_\_\_\_

Contact Number \_\_\_\_\_

Jurisdiction \_\_\_\_\_

Case Name \_\_\_\_\_

Client ID/MA Number \_\_\_\_\_

Application Date \_\_\_\_\_

Current Certification Period \_\_\_\_\_

Retro Period (if applicable) \_\_\_\_\_

Type of Expense (place a check mark next to appropriate type)

\_\_\_\_\_ Dental Bill

\_\_\_\_\_ Hearing Aid Bill

\_\_\_\_\_ Vision Bill

\_\_\_\_\_ Podiatry

\_\_\_\_\_ Nursing Home Bill

Months being requested \_\_\_\_\_

\_\_\_\_\_ Other (please specify) \_\_\_\_\_