TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Texas Medicaid and Healthcare Partnership
12357-B Riata Trace Parkway, Suite 100
Austin, TX 78727

[Insert Date]

Remittance Form

Complete and mail this Remittance Form with a check or money order to:

Texas Medicaid & Healthcare Partnership
Accounts Receivable
PO Box 202948
Austin, TX 78720-2948

To be completed by the provider:

Provider Name: __________

Texas Provider Identifier (TPI): __________

Tax Identification Number (TIN): __________

Certified Mail Return Receipt Number: __________

Total Amount Due: __________

Check Number: __________

Check Amount: __________

Contact Person: __________

Telephone Number: __________