

NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES  
**REQUEST FOR PRIOR MEDICAL ASSISTANCE**

*Medicaid assistance may be requested for up to three months prior to the month of application for public assistance. The client must be eligible in and have proof that medical care or services were provided in the month(s) coverage is requested.*

**COMPLETE THE FOLLOWING INFORMATION FOR THE PERSON MEDICAID IS REQUESTED FOR:**

1. Name: \_\_\_\_\_ Case No.: \_\_\_\_\_

2. Home Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

3. If you are applying for another person, give YOUR name, address, phone number and relationship: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. List all months prior to your assistance application Medicaid is requested for: \_\_\_\_\_

\_\_\_\_\_

5. Proof that medical care or services has been provided during the months requested must be submitted to this office by: \_\_\_\_\_

6. Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

7. Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(Use if the applicant cannot read or write or is blind.)* I have heard the information contained in this application read to the applicant and have witnessed the signature above.

8. WITNESS:

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

9. Case Manager's Signature: \_\_\_\_\_ Date: \_\_\_\_\_