



RECEIPT OF PAYMENT

MAIL

PAYMENT TYPE: CASH MONEY ORDER
 CHECK
 RETURN - UNENDORSED DEPARTMENTAL CHECK

NO.

CO	RECORD NUMBER	CAT	GG	DIST
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CLAIM NAME (Last, First, MI)	SOCIAL SECURITY NUMBER
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ADDRESS - STREET NO., PO BOX, CITY, STATE	ZIP CODE PLUS 4
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NAME OF PERSON MAKING PAYMENT - IF DIFFERENT THAN ABOVE (Last, First, MI)	BUDGET NAME - IF DIFFERENT THAN ABOVE (Last, First, MI)
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ADDRESS - STREET NO., PO BOX, CITY, STATE	ZIP CODE PLUS 4
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TOTAL PAYMENT AMOUNT		DOLLARS	CENTS	UNENDORSED DEPARTMENTAL CHECK DATA			CHECK NUMBER	CHECK DATE
RESTITUTION	\$			<input type="checkbox"/> CASH ASSISTANCE OVERPAYMENT	<input type="checkbox"/> SNAP OVERPAYMENT	<input type="checkbox"/> SNAP E&T SP. ALLOW.	<input type="checkbox"/> MEDICAL ASSISTANCE OVERPAYMENT	DATE OF PA 189 / /
REIMBURSEMENT	\$			<input type="checkbox"/> CASH ASSISTANCE	<input type="checkbox"/> MEDICAL ASSISTANCE		REIMBURSEMENT/SUPPORT CODE (see Reverse of Page 3)	DATE OF FIRM 173S OR TELEPHONE CALL / /
CHILD SUPPORT	\$			<input type="checkbox"/> VOLUNTARY	<input type="checkbox"/> COURT ORDER		DEFENDANT NAME (Last, First, MI)	SUPPORT PAYOR NO. / /

_____ SIGNATURE - CLIENT/CLIENT REPRESENTATIVE	_____ DATE	_____ SIGNATURE - CAO WITNESS	_____ DATE
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_____ SIGNATURE - CAO REPRESENTATIVE	_____ DATE	NOTICE - Your signature confirms that the payment amount shown above is the amount you paid and is correctly noted on this receipt. Payment is accepted on this account. Your claim, or the claim of the person on whose behalf payment is made and any balances or adjustments, will be determined by the Commonwealth.
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COMMENTS





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CHILD SUPPORT	\$			<input type="checkbox"/> VOLUNTARY	DEFENDANT NAME (Last, First, MI)	SUPPORT PAYOR NO.	DATE OF PA/CS 4D	/ /
				<input type="checkbox"/> COURT ORDER				

_____ SIGNATURE - CLIENT/CLIENT REPRESENTATIVE	_____ DATE	_____ SIGNATURE - CAO WITNESS	_____ DATE
_____ SIGNATURE - CAO REPRESENTATIVE	_____ DATE	_____ SIGNATURE - DHS-BFO/OW FIRM CASHIER	_____ DATE

COMMENTS

2A - CAO CASE RECORD

CLAIM NAME (Last, First, MI) _____ COUNTY PROCESSING PAYMENT _____ CO _____ RECORD NUMBER _____ CAT _____ GG _____ DIST _____

TOTAL PAYMENT AMOUNT \$ _____ **PAYMENT TYPE** CASH CHECK MONEY ORDER

NO. _____

 SIGNATURE - CAO REPRESENTATIVE _____ DATE _____

2B - CAO CONTROL FILE





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				<input type="checkbox"/> COURT ORDER				

_____ SIGNATURE - CLIENT/CLIENT REPRESENTATIVE	_____ DATE	_____ SIGNATURE - CAO WITNESS	_____ DATE
_____ SIGNATURE - CAO REPRESENTATIVE	_____ DATE	_____ SIGNATURE - DHS-BFO/OW FIRM CASHIER	_____ DATE

COMMENTS

3A - DHS-BFO/OW FIRM CASHIER

CLAIM NAME (Last, First, MI)	COUNTY PROCESSING PAYMENT	CO	RECORD NUMBER	CAT	GG	DIST
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TOTAL PAYMENT AMOUNT	DOLLARS	CENTS	PAYMENT TYPE	<input type="checkbox"/> CASH	<input type="checkbox"/> CHECK	<input type="checkbox"/> MONEY ORDER
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NO.	_____ SIGNATURE - CAO REPRESENTATIVE	_____ DATE
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3B - CAO TURN AROUND





REIMBURSEMENT CODES		MEDICAL ASSISTANCE CODES	
01	RESERVED	69	TPL - HEALTH INSURANCE
02	SSI	70	TPL - AUTO RELATED
03	UC	72	TPL - DECEDENT'S ESTATE
04	PERSONAL DAMAGE	73	TPL - SELF-INSURED ENTERPRISE
05	RESERVED	74	TPL - WORKER'S COMPENSATION
06	INHERITANCES	75	TPL - LEGALLY RESPONSIBLE RELATIVE
07	SICK BENEFITS	76	TPL - LYING-IN EXPENSES
08	WORKER'S COMPENSATION	77	TPL - MEDICAL CHILD SUPPORT
09	MISCELLANEOUS (i.e. BLACK LUNG, RR PENSION)	80	TPL - OTHER
10	SOCIAL SECURITY SURVIVOR'S & DISABILITY BENEFITS	92	TPL - SLIP AND FALL
11	SOCIAL SECURITY RETIREMENT	93	TPL - MEDICAL MALPRACTICE
12	VETERAN'S BENEFITS (VA)	94	TPL - PRODUCT LIABILITY
13	RESERVED	95	TPL - ASSAULT
14	RESERVED	96	TPL - MOTORCYCLE
15	MINOR'S TRUST FUND	97	LTC - NURSING HOME
16	RESERVED	MEDICAL ASSISTANCE CODES	
		51	CHILD/SPOUSAL SUPPORT PAYMENT
		55	ALIMONY
		59	IV-D RECOVERY

