Washington State
Department of Social
& Health Services
HRSA Health & Recovery
Services Administration

Voucher for Interim Pharmacy and Medical Services for Foster Children

Dear Pharmacist or Physician:

This voucher is to be used in cases when health care services are needed by a child in foster care for whom a medical assistance ID card has not yet been issued. Children are often placed in foster care during non-business hours when ID cards cannot be issued or coverage verified. Please do not withhold medically necessary health care services based on the lack of a medical assistance ID card for a foster child.

Please use this voucher when medically necessary health care services are needed by a child in foster care for whom a medical assistance ID card has not yet been issued. The billing, coverage, and reimbursement policies applicable to health care services provided to children with medical assistance ID cards in categorically needy fee for service Medicaid programs will apply to services you provide to a foster child in reliance on this voucher.

- **Pharmacy providers, please check your Medicaid list of covered drugs to verify product NDC coverage.**
- **All providers: Please create a Partial Medicaid PIC by filling in the following blanks below as instructed. Fill in all other requested information.**
- **Then FAX to "Foster Care Medicaid Team" at (360) 586-0605. They will FAX back a Medical ID card within 5 business days (Monday - Friday, 8:00 a.m. - 5:00 p.m.), with which you can retro-bill.**
- **If you have not received the patient's Medical ID card via fax in 5 business days please call the foster care medical unit at 1-800-547-3109. If they are not able to provide a sufficient answer please call: Sylvia Soto, Foster Care Program Manager at 360-725-1517. Pharmacists can call Jeff Rochon at the Washington State Pharmacy Association: 425-228-7171.**

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Enter first letter of the first name in space 1		Enter middle initial in space 2			Enter the first five (5) letters of the Child's Last Name in spaces 3 - 7						Enter child's birth date in MM DD YY format in spaces 8 - 13					

Child's name:	Gender: ☐ Male ☐ Female	DATE OF SERVICE
Foster parent's name:		
Address:		
City, zip code, telephone number (include area code):		
Physician or pharmacy name:		
Address:		
City, zip code, telephone number (include area code):		
Fax number (include area code):		
Contact name:		