RECOVERY TECHNOLOGY L.L.C.

_____

Deductible /Spend Down

Client Name:_____Case #_____

Medicaid #: _____

To: Medicaid Deductible Worker: _____

Department of Human Services
P.O. Box 3007
Jackson, MI 49204

This letter is to verify that _____ received the following Medicaid billable service charges.

Date	Service	Amount

Deductible Amount: $0.00_____please contact RECOVERY TECHNOLOGY LLC if this is incorrect.

Respectfully,

_____ _____

Clinician's Signature Credentials Printed Clinician's Name