



**DEPARTMENT OF HEALTH
AND HOSPITALS**
Medicaid

ORDER FORM

Date			
Name of Application Ctr.		Application Ctr. #	
Street Address (No P.O. Boxes)		AC Telephone #	
City, State, Zip		AC Fax #	
Contact Person		Direct phone #	

Indicate the quantity of PACKS being requested below.					
# of PACKS Req.	# per PACK (pk)	DOCUMENT NAME	# of PACKS Req.	# per PACK (pk)	DOCUMENT NAME
	50	1-CH LaCHIP (flyer & application)		50	1-PW LaMoms (flyer & application)
	50	1-FOA Family Opportunity Act (flyer & application)		100	Flyer—F&F—Friends and Family Transportation Program
	50	1-FP TAKE CHARGE Family Planning (flyer & application)		100	Flyer—La.'s Medicaid Program
	100	1-G General Application (application only)		100	Flyer—Medical Services
	50	1-MB Medicare Savings Program (flyer & application)		100	Flyer—NEMT—Non-emergency transportation program
	50	1-MPP Medicaid Purchase Plan (flyer & application)		200	Flyer—7 Program Summary
				100	Flyer—WIC 43—WIC flyer

Email Order form to: ACService@la.gov

Or Fax to: 1 (225) 376-4736

Any questions regarding ordering forms should be directed to the
Medicaid Application Center Unit: (225) 342-0462.