S T A T E O F C O N N E C T I C U T
D E P A R T M E N T O F S O C I A L S E R V I C E S
S B C H P R O G R A M - R E I M B U R S E M E N T A N D C O N
5 5 F A R M I N G T O N A V E N U E · H A R T F O R D , C T 0 6 1 0 5 - 3 7 2 5
Phone: 860-424-5386 Fax: 860-424-4812

SBCH Contacts for Enrolled Districts

The purpose of this form is to identify the individuals in each participating district who should be contacted for various aspects of the SBCH program. Please complete the following sections and identify items as applicable for contact details.

School District Name:____ LEA Number: _____________

Primary Contact:

Name:		Phone:	
Title:		Email:	

General Program Information:

Name:		Phone:	
Title:		Email:	

Statistics/Snapshots:

Name:		Phone:	
Title:		Email:	

Medicaid Billing Payment Notifications:

Name:		Phone:	
Title:		Email:	

Billing Vendor (if applicable):

Billing Vendor Name**:** ____

Items to grant access to:

__________ Medicaid Billing

__________ Payments

__________ RMTS

__________ Cost Reports & Admin Claiming

__________ Statistics/Snapshots

__________ DXC Eligibility verification system

Billing Vendor Contact 1:

Name:		Phone:	
Title:		Email:	

Billing Vendor Contact 2:

Name:		Phone:	
Title:		Email:	

Billing Vendor Contact 3:

Name:		Phone:	
Title:		Email:	

Billing Vendor Contact 4:

Name:		Phone:	
Title:		Email:	

School District Authorization:

____ ____

Printed Name Signature

____ ____

Title of District Representative Date

Please submit completed form to:
CT Department of Social Services, SBCH Program
Email: dss.sbch@ct.gov