Maternity Services Program
Specialized Test Invoice*

Month:_____ **Practice Name:_____** **Health Center:_____**

Social Security Number or Health Center Chart #	Reason for Referral	Date of Test	Name of Test	Procedu
				Prepared by **Phone:**
				Authorized

*This form is to request reimbursement for specialized tests provided for MSP patients, who are **uninsurable**. Use a separate table for each site. Please total all charges. Attach legible copy of test results.