

FOR TDSHS USE ONLY	
Date Received	Date Returned to County

**COUNTY INDIGENT HEALTH CARE PROGRAM  
 FACILITY PAYMENT RATE REQUEST**

County	Submitted by	Fax Number	Telephone Number	Date Submitted to TDSHS

<b>Name of Facility:</b> _____ <b>Address of Facility:</b> _____ <b>County of Facility</b> _____ Facility's 9-digit <b>Texas Provider Identifier (TPI) #:</b> _____ Please check <input type="checkbox"/> for rate(s) requested →	<b>TDSHS PAYABLE</b> Please check <input type="checkbox"/> for rate(s) requested
	<input type="checkbox"/> Inpatient Rate:
	<input type="checkbox"/> Outpatient Rate:
	<input type="checkbox"/> SDA:
	<input type="checkbox"/> Rate Per Visit:
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