COVID19 Provider Benefit Stabilization Request Form

Cover Loss Revenue for March 16, 2020 – September 30, 2023

Please complete the following and submit to MCN:
Organization:
Request Date:
Dates covered:
Request Amount:
Requestor name:
Requestor title:
Requestor email:
Requestor phone number:
INTERNAL USE ONLY Finance Staff Recommendation (approve/deny):
Support reason (list claims review justification):
Denial reason:
MCN Finance Staff initials:
MCN CFO approval initials:
Funds Disbursement Date: