10397

HOME & COMMUNITY BASED CARE FOR THE ELDERLY/DISABLED AND DEVELOPMENTALLY DISABLED BILLING FORM

North Dakota Department of Health and Human Services

SFN 1730 (9-2025)

Billing Period:

M M / D D / Y Y Y Y: 08 / 18 / 2025

through

M M / D D / Y Y Y Y: 08 / 31 / 2025

Provider Number: 14XXXXX

Provider Name (Last, First, MI): Doe, John

Recipient ID Number: NDXXXXXXX

Recipient Name (Last, First, MI): Doe, Jane

Providers: Retain a copy for your records.

Procedure Code	From Day		Through Day	Units	Billed Amount
00001	18	TH	18	001	00074.69
00001	19	TH	19	001	00074.69
00001	20	TH	20	001	00074.69
00001	21	TH	21	001	00074.69
00001	22	TH	22	001	00074.69
00001	23	TH	23	001	00074.69
00001	24	TH	24	001	00074.69
00001	25	TH	25	001	00074.69
00001	26	TH	26	001	00074.69
00001	27	TH	27	001	00074.69
00001	28	TH	28	001	00074.69
00001	29	TH	29	001	00074.69
00001	30	TH	30	001	00074.69
00001	31	TH	31	001	00074.69
		TH			.
		TH			.
		TH			.

Use only when correcting claim **Original Claim Number:**

☐ **Void**

☐ **Replacement**

Certification and Agreement of Providers: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and accept, as payment in full, the amounts paid, and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable federal or state laws. That the services herein charged were actually rendered and were rendered under the conditions specified; and that no part of such bill, claim, account or demand has been paid. That the services provided and billed for qualify for federal participation under 42 USC 1396 (A) ET. SEQ. and that rules and regulations promulgated and adopted thereunder. I further certify that goods and services hereby designated are furnished without discrimination as to age, sex, race, color, national origin, political affiliation or handicap. I agree to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the state plan and to furnish the state agency with such information, regarding any payments claimed by such person or institution forproviding services under the state plan, as the state agency may from time to time request.

Provider Signature: John Doe Date: 09/16/2025