10397

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

North Dakota Department of Health and Human Services
SFN 1730

Provider Number EXAMPLE

Billing Period: MM/DD/YYYY 05/01/2025 through 05/31/2025

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

Recipient ID Number 02EXAMPLE

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

Procedure Code	From Day		Through Day	Units	Billed Amount
00001	18	TH	18	1	74.69
00001	19	TH	19	1	74.69
00001	20	TH	20	1	74.69
00001	21	TH	21	1	74.69
00001	22	TH	22	1	74.69
00001	23	TH	23	1	74.69
00001	24	TH	24	1	74.69
00001	25	TH	25	1	74.69
00001	26	TH	26	1	74.69
00001	27	TH	27	1	74.69
00001	28	TH	28	1	74.69
00001	29	TH	29	1	74.69
00001	30	TH	30	1	74.69
00001	31	TH	31	1	74.69
		TH			
		TH			
		TH			

Providers: Retain a copy for your records.

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: 06-1-25

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

North Dakota Department of Health and Human Services
SFN 1730

Provider Number EXAMPLE

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

Recipient ID Number 02EXAMPLE

Billing Period: MM/DD/YYYY 05/01/2025 **through** 05/31/2025

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

Providers: Retain a copy for your records.

Procedure Code	From Day		Through Day	Units	Billed Amount
00001	01	TH	01	1	74.69
00001	02	TH	02	1	74.69
00001	03	TH	03	1	74.69
00001	04	TH	04	1	74.69
00001	05	TH	05	1	74.69
00001	06	TH	06	1	74.69
00001	07	TH	07	1	74.69
00001	08	TH	08	1	74.69
00001	09	TH	09	1	74.69
00001	10	TH	10	1	74.69
00001	11	TH	11	1	74.69
00001	12	TH	12	1	74.69
00001	13	TH	13	1	74.69
00001	14	TH	14	1	74.69
00001	15	TH	15	1	74.69
00001	16	TH	16	1	74.69
00001	17	TH	17	1	74.69

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: 6-1-25