NORTH Dakota | Health & Human Services
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Instructions to Complete the HCBS and DD Billing Form: SFN 1730

Follow these instructions **exactly** to make sure your claim form is filled in correctly.

Do not cross over lines when filling in the boxes, only one number or letter in each box.

1. **Provider Number** - Enter the seven-digit provider (QSP) number you were given when you enrolled.

2. **Provider Name** Enter your full name: **LAST NAME**, First name, middle initial (if used).

3. **Billing Period**
   - Only bill for one month at a time on one claim form.
   - In the top boxes, enter the first day of the month in which you provided services to a client.
   - In the bottom boxes, enter the last day of the month you provided services to a client.
   - Use two digits for the month, two digits for the day and two digits for the year.
     Example: June 2024 is entered as: **06/01/24** through **06/30/24**

4. **Recipient ID Number**
   - This is the assigned Medicaid ID number for your Recipient (also known as Client, Member or the Individual you are providing care to). The number will always start with "ND". Make sure to **include** the "ND" when you write the number on the claim form.
   - You will find the number on your on your Service Authorization (SA).

5. **Recipient Name**
   - Enter the LAST NAME, First name, middle initial (if used) of your client.
   - Their name must be spelled the same as on the Service Authorization; do not use nicknames (Example: Jim for James).
   - If you have **more than one month of services** to bill, use a new claim form for each month.
   - If you have **more than one client**, use a new billing form for each client.

6. **Procedure Code**
   - Enter the Procedure Code for the service you provided to your client. You will find the Procedure Code on your Service Authorization.
   - All 5 boxes must be filled. Example, when billing for Family Home Care, the Procedure Code is "00001", you must add the "zero's" before the one: 00001
   - More than one code can be billed on the same form if it is for the **same client**.
   - The entire month of services can be billed on one line **if there was no break in providing services during the month**.
     - If there was a break in services – which means, if there were days that you did not provide services, and then started to provide again, do not bill for the days you did not provide services. Enter a line for the days you did provide services, then start a new line for the other days you provided services, skipping any days you did not provide services to your client.
       Example:

Procedure Code	*From Day*	*Through Day*	*Units*	*Billed Amount*
00001	01	15	15	(see auth for amount)
00001	20	31	11	(see auth for amount)

   - There is room for 17 entries. If your client received care on more than 17 days during the month, use two forms to enter the data. Make sure to add all of the information on the top of the second form.
   - Do **not** staple the forms together.

7. **From Day**
   - Enter the two-digit number for the day of the month you provided services to your client on each line being billed. Example: June 2 is entered as “02”.

8. **Through Day**
   - Enter the two-digit number for the day of the month you provided services to your client on each line being billed. Example: June 2 would be entered as “02”.
   - If you are billing for more than one day (for example, an entire month), enter the first day of service in the “From Day” column and the last day of service in the “Through Day” column. Remember, **do not bill for days you did not provide services**.

9. **Units**
   - Enter the number of units you are billing for that day. The number of units will always be a whole number. **Never** use a decimal point on the billing form. Example: 3 units are entered as 3.

		3

10. **Billed Amount**
    - The billed amount is the rate set by the Department for each procedure code multiplied by the number of units provided on one day.
    - The rate you are authorized for your client is shown on the Service Authorization you receive from the Case Manager.
    - If billing one day, multiply one day times the authorized rate and enter that amount in the billed amount. Example **ONLY**: If your authorized rate is $15.00 per day:

Procedure Code	*From Day*	*Through Day*	*Units*	*Billed Amount*
00001	01	01	1	$15.00 *(Example ONLY)*

If billing more than one day at a time, take the number of days, times the authorized rate and enter the full amount in the billed amount. Example **ONLY**: If your authorized rate is $15.00 per day:

Procedure Code	*From Day*	*Through Day*	*Units*	*Billed Amount*
00001	01	15	15	$225.00 *(Example ONLY)*

11. Original Claim Number and Void Replacement Boxes
    - **Do not enter anything in these boxes. Leave all blank or it may delay processing of your claim!**

12. **Provider Signature**
    - **Make sure to sign and date** the billing form. Claims received without a signature or date will not be processed and you will not be paid.

13. Make a copy of the form to keep for your records.

➢ **Still need help? The Call Center can help with questions:**
Call 1-877-328-7098, when asked for a PIN, select “0”

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Important Information:

- **Service Authorizations (SA's)**
  - You may only bill for services that you actually provided to your client and that you are authorized to provide to your client. "Authorized" means you have received a Service Authorization from your clients Case Manager (CM).

- **Mailing Your Billing Forms**
  - For faster processing, send your claim form as soon as you are done completing services for the previous month.
  - **DO NOT** fill out the claim form and send it in before the end of the month.
  - The US Mail runs slow, to check if your claim has been received, call the **Automated Payment Line at 1-866-768-2435.** Use your QSP number to check the status of your claim.
  - **Mail completed billing forms to:**
    ATTN: HCBS BILLING FORM
    N.D. Department of Health and Human Services
    600 E Boulevard Ave Dept 325
    Bismarck, ND 58505-0250
  - **Billing online** in the MMIS Portal can be a time saver! Some benefits of online billing are:
    - No waiting for your claim form to be delivered by mail; claims are sent electronically.
    - Better chance of your claim paying on the first try
    - Once you submit the claim, you'll know right away if your claim is going to pay.
    - No scanning errors and problems caused by missing information.
    - No more trying to write inside all of the boxes on the paper forms.
    - To sign up for online billing in MMIS: email MMISinfo@nd.gov or Call 1-877-328-7098, when asked for a PIN, select "0".

- **Remittance Advice (RA)**
  - When a claim is done processing, you will receive a Remittance Advice (RA). If payment is made, a check will be sent to you or deposited directly into your bank account. If the claim is denied or you don't get the full amount of what you were expecting, the RA tells you why.
  - If a claim or a part of a claim was denied/not paid and you believe the action was wrong, contact the MMIS Call Center for assistance email MMISinfo@nd.gov or Call 1-877-328-7098, when asked for a PIN, select "0".

- **Additional Billing Forms**
  - Do not make your own copies of the blank billing forms because they may be rejected by the scanner. If you need more blank billing forms, email QSPinfo@ND.Gov to request more.

10397

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

North Dakota Department of Human Services
SFN 1730

1 Provider Number

2 Provider Name (Last, First, MI)

3 Billing Period: M M / D D / Y Y Y Y through M M / D D / Y Y Y Y

4 Recipient ID Number

Recipient Name (Last, First, MI)

5

6 Procedure Code	7 From Day		8 Through Day		9 Units	10 Billed Amount
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
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Providers: Retain a copy for your records.

11 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.

12 Provider Signature: _____ Date: _____