NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

INSTRUCTIONS FOR COMPLETING CARE COORDINATION ORGANIZATION'S BILLING FORM

This form should be completed for ALL service types provided.

Please note that multiple billing forms for multiple service types can be attached to ONE Standard Voucher (AC92) or Claim for Payment (AC3253-S) form, for each billing. Submit vouchers for payment no earlier than the first day of the month following service delivery.

CARE COORDINATION ORGANIZATION: Enter your CCO's full name.

FEDERAL EMPLOYER ID#: Enter your CCO's 9-digit federal employer ID number.

VENDOR ID#: Enter your CCO's 10-digit Statewide Financial System (SFS) Vendor ID number.

CCO CONTACT PERSON: Enter the name of the person at your CCO who can be contacted to resolve any problems or questions regarding the billing form.

PHONE #: Enter a phone number, including area code and any extension, at which the contact person can be reached.

MONTH / YEAR OF SERVICE: Enter the month and year in which the services that are being billed, were provided. **Please note that initial claims received on 11/01/18 and after for services that are more than 3 months past the beginning service month of July 2018, must be accompanied by a letter explaining the late billing. OPWDD will only pay late submissions if the reason(s) for the late submission, was beyond the CCO's control**.

SERVICE TYPES:

WCS	Willowbrook Class Member - ICF/IID, 3rd letter of Price ID is V
WSC	Willowbrook Class Member - NH/Other, 3rd letter of Price ID is V
SC	State Paid Care Management, 3rd letter of Price ID is V
EI	State Paid Care Management for Waiver enrolled – EI Children

Note: Each CCO has been assigned a statewide Price ID for each of the four (4) service types listed above.

INDIVIDUAL NAME: Enter the name of the person receiving the service during the month. The name should be entered: Last Name, First Name and listed in alphabetical order.

TABS ID: Enter the TABS (Tracking & Billing System) ID number for the participant. (If unknown your DDRO contact will be able to supply you with this number).

PRICE ID: Enter the Price ID number that has been provided by OPWDD.

SERVICE TYPE: Enter the type of service to be billed on each claim line, as described in Service Types above.

AMOUNT PAYABLE: Enter the amount that should be paid to your CCO for each services type provided to the participant during the month of service. The amount payable is based on the **monthly fee** associated with each service type.

PAYEE SIGNATURE: The signature of your Executive Director or designee

TITLE: The title of the person signing the form

DATE: The date the Billing form was completed

ATTACH FORM(S) TO A COMPLETED STANDARD VOUCHER (AC92) OR CLAIM FOR PAYMENT (AC3253-S) AND MAIL TO:
NYS OPWDD, Bureau of Central Operations, Payment Processing Unit, 4th Floor, 44 Holland Ave., Albany, NY 12229