INSTRUCTIONS FOR COMPLETING PCSS STATE PAID SERVICES BILLING FORM FOR SERVICES RECEIVED ON OR AFTER 09/01/2013

This form should be completed for non waiver / non-Medicaid individuals who received PCSS services on or after 09/01/2013 or for waiver individuals enrolled in early intervention (EI) who received PCSS services on or after 09/01/2013

Please note that multiple billing forms can be attached to ONE Standard Voucher (AC92) or Claim for Payment (AC3253S) for each billing. Submit vouchers for payment no earlier than the first day of the month following service delivery.

AGENCY NAME: Enter your full Agency name

FEDERAL EMPLOYER ID#: Enter your Agency's nine digit federal employer ID number

VENDOR ID#: Enter your Agency's ten digit Statewide Financial System (SFS) Vendor ID number

DDSO: Enter the name of the DDSO that is the contact for your Agency

AGENCY CONTACT PERSON: Enter the name of the person at your Agency 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 for were provided. Please note that only one (1) unit allowed per month/year for an individual and that Early Intervention (EI) individuals are limited to two (2) units in a 12 month period and Non-EI individuals are limited to four (4) units in a 12 month period. **Also note that initial claims submitted 10/01/13 or after for services more than 3 months past the service month must be accompanied by a letter explaining the late billing. OPWDD will only pay late submissions if the reason why submitted late was beyond provider's control.**

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

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

PROVIDER ID: Enter the PROVIDER ID number that has been provided by your DDSO

UNIT: Please note that only one (1) unit allowed per month/year for an individual

FEE: Enter the Fee per unit that was provided to your Agency by your DDSO contact

AMOUNT PAYABLE: Enter the total amount that should be paid to your Agency for services provided to the participant during the month of service. The amount payable is the Unit multiplied by the Fee.

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 (AC3253S) AND MAIL TO:

NYS OPWDD, Bureau of Central Operations, Payment Processing Unit, 4th Floor, 44 Holland Ave., Albany, NY 12229