INSTRUCTIONS FOR COMPLETING MULTI-SERVICE PROVIDER ID BILLING FORM

This form should only be used for Multi-Service Provider ID services that have been provided AND for which there is no specific OPWDD billing form. Please note that multiple billing forms for multiple service types 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

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

SERVICE RATE CODES: Please enter the applicable 4 digit rate code for the service provided. Note: Rate codes cannot be mixed on the form.

LOCATOR CODE: Please enter the applicable 3 digit rate code associated with the Service Description (if only a 2 digit Locator Code is known, enter "0" as the first digit). Locator Code is determined based on your corporate office location for the identified service description. Locator Codes cannot be mixed on the form.

PROVIDER ID#: Enter the eight digit Provider ID number your agency would use to bill if individual was HCBS enrolled

MONTH / YEAR OF SERVICE: Enter the month AND year in which the service(s) that are being billed for were provided. Please 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)

 # ¼ Hr. UNITS: Enter the total number of ¼ hour units of service the participant received during the month (i.e. Participant received 4 hours of service, the field **"# ¼ Hr. UNITS"** would then show 16 units**)**

FEE: Enter the Fee per unit that was provided by the Department of Health (DOH)

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 number of ¼ Hr. Units 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 COMPLETED BILLING FORM TO:

NYS OPWDD
BUREAU OF CENTRAL OPERATIONS
PAYMENT PROCESSING UNIT – 4TH FL.
44 HOLLAND AVENUE
ALBANY, NEW YORK 12229