

**INSTRUCTIONS FOR COMPLETING SUPERVISED IRA/CR RESIDENTIAL
HABILITATION BILLING FORM FOR NON-WAIVER INDIVIDUALS RECEIVING
SUPERVISED IRA/CR RESIDENTIAL HABILITATION SERVICES
ON OR AFTER 7/1/14**

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 10 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.

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

PROVIDER ID#: Enter the eight digit Provider ID number that has been provided by your DDSO contact

LOCATOR CODE: Enter the Locator Code provided by your DDSO contact

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)

SUPERVISED IRA/CR RESIDENTIAL HABILITATION RATE CODES, # OF DAYS, PER DIEM

Please fill in the # OF DAYS of services provided to the individual during the month of service per appropriate Rate Code, and Per Diem.

AMOUNT PAYABLE: Calculate the total amount that should be paid to your Agency for services provided to the individual during the month of service.

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