



**This form should be completed by the FI for 100% New York State Funded Items provided on or after 08/01/19**

**Use one form per service month – multiple services provided to an individual during a service month may be claimed on the same billing form. Multiple billing forms can be attached to ONE Claim for Payment (AC3253S) for each billing**

AGENCY NAME: Enter your full Agency name

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

SFS 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 may 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

AGENCY CONTACT PERSON E-MAIL: Enter the e-mail address of the agency contact person

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 each individual receiving services during the month. The names 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.

SERVICE INDICATOR CODE: Enter the appropriate Service Indicator: **BSSD** (Budgeted State Service Dollars), **VL** (Vehicle Lease), **MES** (State Funding to Maintain Existing Services with IDGS), **OPRA** (State Funding for Amount over PRA) OTHER (OPWDD will define at a later date)

UNITS: Enter the total number of Units corresponding to the total to be reimbursed by taking the total expenditure and dividing by \$10.00. If result is a whole number, enter that number as the Units. If result has decimal, enter only the whole number as the Units. Roll any unpaid expenditures to the next month. For example a total expenditure of \$112.00 divided by \$10.00 yields 11.2 Units. Enter only the 11 in the Units column. Roll the unreimbursed \$2.00 to the next month.

UNIT FEE: The fee is set at \$10.00 per unit.

AMT BILLABLE TO OPWDD: Multiply the Units by \$10.00 and enter the resulting total in the column.

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

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**ATTACH BILLING FORM(S) TO A COMPLETED CLAIM FOR PAYMENT (AC3253S) AND MAIL TO:**  
NYS OPWDD, Bureau of Central Operations, Payment Processing Unit 4th Floor, 44 Holland Avenue, Albany, NY 12229