MULTI-SERVICE PROVIDER ID BILLING FORM

FOR NON-WAIVER INDIVIDUALS IF NO SPECIFIC SERVICE BILLING FORM AND AGENCY WOULD USE MULTI-SERVICE PROVIDER ID IF BILLING TO MEDICAID

AGENCY NAME: _____

FEDERAL EMPLOYER ID #:_____DDSO: _____

CONTACT PERSON: _____PHONE #:_____

Service Description	Rate Code	Locator Code	Provider ID
☐ **Family Care Residential Habilitation** ☐ **Community Based Prevocational Service** ☐ **Hourly Respite 1:Group (non-HCBS enrolled individual)** ☐ **Other: _____**	__ __ __ __	__ __ __	__ __ __ __ __ __ __ __

MONTH / YEAR OF SERVICE: _____

Initial claims for services more than 3 months after the service month must be accompanied by a letter explaining the late billing.

	INDIVIDUAL NAME *(Last Name, First Name)*	***TABS ID***	***# ¼ Hr.UNITS***	***FEE***	***AMOUNT PAYABLE***
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
TOTALS FOR PAGE					**$**

PAYEE CERTIFICATION: *I certify that the care, services and supplies identified have been furnished in accordance with a service plan for each person listed above. The amounts listed are due and except as noted, no part thereof has been paid. Office for People with Developmental Disabilities (OPWDD) payment of the claim will be accepted as payment in full, and there will be no further claim made for payment from OPWDD or the State for the identified care, services and supplies. I certify that there has been compliance with Title VI of the Federal Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 without discrimination on the basis of race, color, national origin, sex or disability. I certify that, as a provider, this agency has complied in full with the OPWDD regulation 14 NYCRR Subpart 635-12 (Liability for Services); that, for each individual on this billing form or computer generated attachment, this agency has given copies of the required fee schedule and notice to the individual receiving services and liable parties, and that, except with respect to services for which OPWDD has approved a waiver of the fee, this agency has presented each individual and liable party with a timely bill for the identified services and is making reasonable efforts to collect on the bill. I certify that such records as are necessary to disclose fully the extent and frequency of care, services and supplies provided shall be kept for each individual and that information will be furnished regarding any payment claimed therefore, as OPWDD or other State agency may request. These records must be kept for six (6) years from the date of submission for payment. I understand that payment and satisfaction of this claim is from State public funds, that the State will make payment based on this certification, and that I may be prosecuted under applicable State laws for any false claims, statements, documents or concealment of material fact.*

_____ _____ _____

PAYEE SIGNATURE **TITLE** **DATE**

ATTACH FORM(S) TO A COMPLETED STANDARD VOUCHER (AC92)/ CLAIM FOR PAYMENT (AC3253S) AND FORWARD TO:
NYS OPWDD, Bureau of Central Operations, Payment Processing Unit, 4th Floor, 44 Holland Ave., Albany, NY 12229