State of Illinois
Department of Human Services

PAYEE DESIGNATION/AUTHORIZATION FORM

SERVICE PROVIDER NAME: _____

FEDERAL TAXPAYER IDENTIFICATION NUMBER (TIN) _____

PAYEE NAME (if different): _____

FEDERAL TAXPAYER IDENTIFICATION NUMBER (TIN) _____

SERVICE PROVIDER CERTIFICATION

I authorize the above specified payee agency to submit bills to the Department of Human Services on my behalf and designate the payee specified above to receive payment for services that I delivered to persons in a Medicaid Home and Community-Based Services Waiver for individuals with developmental disabilities.

The time period for this authorization is from _____ through _____ .

NOTE: The time period may **not** be for more than one State fiscal year. This authorization must be renewed at the start of each State fiscal year.

I certify that the services submitted by my authorized payee agency are true, accurate and complete. I further certify that the services are proper charges against the State of Illinois and that payment has **not** been received from any other source. I certify that the services listed above were provided in accordance with applicable Medicaid requirements and with other applicable rules and guidelines as defined by the Illinois Department of Human Services Division of Developmental Disabilities.

I agree to keep and make available such hard copy records and source documents associated with the above-described services as necessary to disclose fully the nature and extent of services provided and to furnish such information regarding any payments claimed as State and Federal officials may request. I understand that payment is made from State and Federal funds and that any false claims, statements, or documents, or concealment of material facts may be cause for criminal prosecution or other appropriate legal action.

_____
Service Provider Signature

Printed Name: _____

Date: _____ Telephone: _____ Extension: _____

PAYEE CERTIFICATION

I agree to submit bills on behalf of the service provider specified above and to be held financially liable for any bills sumbitted without written documentation from the provider that the services were delivered as detailed in the bills.

_____
Payee Signature

Printed Agency Name: _____

Date: _____ Telephone: _____ Extension: _____

MAIL TO: Medicaid Waiver Unit, DHS Division of DD, Centrum Building, 319 East Madison Street, Suite 3M, Springfield, Illinois 62701

Reset Form Print Form