State of Illinois
Department of Human Services - DD and MH Fee-For-Services Programs

Request for Payment - Billing by Provider - Event

Provider Name: _____ Fed. Taxpayer I.D. No. (FTIN): _____

Payee Name: _____ Fed. Taxpayer I.D. No. (FTIN): _____

Program Code: _____ Service Month: _____ Rate Level (55W only) _____

Individual SSN: _____ Individual Name: _____

1 $ _____ . ___ ___	2 $ _____ . ___ ___	3 $ _____ . ___ ___	4 $ _____ . ___ ___
5 $ _____ . ___ ___	6 $ _____ . ___ ___	7 $ _____ . ___ ___	8 $ _____ . ___ ___
9 $ _____ . ___ ___	10 $ _____ . ___ ___	11 $ _____ . ___ ___	12 $ _____ . ___ ___
13 $ _____ . ___ ___	14 $ _____ . ___ ___	15 $ _____ . ___ ___	16 $ _____ . ___ ___
17 $ _____ . ___ ___	18 $ _____ . ___ ___	19 $ _____ . ___ ___	20 $ _____ . ___ ___
21 $ _____ . ___ ___	22 $ _____ . ___ ___	23 $ _____ . ___ ___	24 $ _____ . ___ ___
25 $ _____ . ___ ___	26 $ _____ . ___ ___	27 $ _____ . ___ ___	28 $ _____ . ___ ___
29 $ _____ . ___ ___	30 $ _____ . ___ ___	31 $ _____ . ___ ___	

CERTIFICATION AND APPROVAL: I certify that the servces listed above 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 Medicaid requirements and with other applicable rules and guidelines as defined by the Illinois Department of Human Services.

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 CERTIFICATION (Executive Director or professional practitioner)

Signature: _____

Printed Name: _____

Date: _____ Telephone: _____

Extension: _____