State of Illinois
Department of Human Services

DD and MH Fee-For-Service Programs - Request for Payment Billing by Provider-Hourly

PROVIDER NAME: _____ FED. TAXPAYER I.D. NO. (FTIN) _____

PAYEE NAME: _____ FED. TAXPAYER I.D. NO. (FTIN) _____

PROGRAM CODE: _____ SERVICE MONTH: _____ RATE LEVEL (IF APPLICABLE): _____

INDIVIDUAL SOCIAL SECURITY NUMBER: _____

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	:																		

MILEAGE (IF 87D): $ _____ OVERNIGHTS (IF 87D): $ _____

CERTIFICATION AND APPROVAL: I certify that the services 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 applicable 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: _____