State of Illinois
Department of Human Services - Office of Rehabilitation Services - Home Services Program

Case Management Monthly Billing Statement

Vendor FEIN: _____ Vendor Name: _____

Vendor Address: _____

City/State/Zip: _____

Customer Name	Case Number	Social Security Number	District	Services Dates From/To	Type Service	Service Description	Units	Unit Price	Amount Billed	For ORS USE ONLY Authorization Number

I hereby certify that the above listed services were provided during the stated dates to the stated customer(s).

VENDORS PLEASE NOTE: The signature below also certifies that the information governs herein by the provider is true, accurate and complete, that the charges considered reasonable by the Department of Human Services - Office of Rehabilitation Services will constitute the full and complete charges. Therefore, that the provider will not accept additional payment from the client or any other source and insurance or other payments for this services are considered as deductions from the authorized amount.

Vendor Signature: _____ Date: _____

ORS Approval Signature: _____ Date: _____

Distribution: Original - Office of Rehabilitation Services Local Office
Copy - Vendor

Print Form Reset Form

Case Management Monthly Billing Statement

INSTRUCTIONS FOR COMPLETION

1. **Enter the vendor's FEIN and the 12 character rate agreement number.**

2. **Enter the vendor's name and address to which payment is to be sent.**

3. **Enter the page number of this form and the total number of pages included in the billing to ensure all pages have been received by Office of Rehabilitation Services.**

4. **Enter the customer's name.**

5. **Enter the customer's seven digit case number assigned by Office of Rehabilitation Services.**

6. **Enter the customer's Social Security number.**

7. **Enter the Office of Rehabilitation Services district number. NOTE: One form must be completed for each district to which services are being billed.**

8. **Enter the dates the services were provided. Each month must be billed separately on a line. Multiple months may be billed the the same form, using a separate line for each month billed.**

9. **Enter the Office of Rehabilitation Services type of service and service description codes as indicated here.**

Case Management	**50-04184**
Case Management Assessment	**50-04185**
Case Management Reassessment	**50-04186**
Automobile Transportation	**50-08502**

10. **Enter the total amount billed for the service.**

11. **For Office of Rehabilitation Services use only.**

12. **The form is signed and dated by the appropriate vendor staff person.**

13. **The form is submitted for payment to the local Office of Rehabilitation Services office which handles cases for which services are being billed.**

A computer generated facsimile of this form may be used to place of the printed form if it is an exact replica of this form.