

Medicaid Home and Community-Based Services Waiver Programs

Living at Home Waiver Billing Form

Waiver Participant Information						Provider Information	
Waiver Participant's Last Name <input style="width: 100%; height: 20px;" type="text"/>						Provider Number <input style="width: 100%; height: 20px;" type="text"/>	
First Name <input style="width: 100%; height: 20px;" type="text"/>						Provider Name <input style="width: 100%; height: 20px;" type="text"/>	
Participant's Medical Assistance Number <input style="width: 100%; height: 20px;" type="text"/>						Address <input style="width: 100%; height: 20px;" type="text"/>	
<input style="width: 100%; height: 20px;" type="text"/>						City, State Zip <input style="width: 100%; height: 20px;" type="text"/>	

#	Date of Service			Procedure Code	Units of Service	Description of Service	Charges
	Month	Day	Year				
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							

LAH Use Only Invoice Process LAH Staff Initials Date Processed	LAH WILL NOT PAY FOR SERVICES RENDERED UNLESS YOU SUBMIT THIS INVOICE WITHIN NINE (9) MONTHS OF DATE YOU PROVIDED THE SERVICE.	Total <input style="width: 100%; height: 20px;" type="text"/>
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I do solemnly declare and affirm under the penalties of perjury that the contents of the foregoing document are true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws. I certify that the services shown on this report were rendered and that no charge has been or will be made for payment from the participant, the participant's family or other source, except as authorized by the Program. I certify further that all reasonable measures to identify and recover third party liabilities to the participant have been taken and all such collections therefrom have been or will be reported to the State. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to Title XIX recipients and to furnish information regarding any payments claimed for providing such services as the State may request for six years from the service date. Payment is hereby requested.

Date:	Provider's Signature:
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