

471-000-60 Instructions for Completion of Form HHS-5N, "N-FOCUS Health and Human Services Billing Document" (previously Form MC-82, "Personal Assistance Claim Form")

Form MC-82, "Personal Assistance Claim Form", has been replaced by Form HHS-5N, "N-FOCUS Health and Human Services Billing Document". This form is completed on N-FOCUS.

NOTICE:

The claimant hereby certifies that the foregoing claim is accurate. All services provided were in compliance with Nebraska Health and Human Services Nebraska Administrative Code Titles 465, 471, 473, 474, and 480, whichever are applicable. The claimant is aware that a false claim may result in prosecution for fraud. Under penalty of applicable Federal and State laws, I certify that representations herein are true and complete, and that no additional payment will be claimed.

Instructions for Completion of N-Focus Health and Human Services Billing Document

Field 1:

- A. Office Number: Enter the **Office Number** from the Provider Authorization.
- B. Office Name: Enter the name of the office from the Provider Authorization.
- C. HHS Provider ID: Enter the **Provider ID** number from the Provider Authorization.
- D. Owner Tax Number: Enter the **Owner Tax ID** number from the Provider Authorization.
- E. Provider Name: Enter the name of the **Provider** from the Provider Authorization and the provider address.
- F. Telephone Number: Enter the **Telephone Number** of the provider from the Provider Authorization.

Field 2: This field represents the line number of the billing document.

Field 3: Client Name: Enter the name of the **Authorized Client** from the Provider Authorization.

Field 4: Client ID Number: Enter the **Client ID Number** from the Provider Authorization.

Field 5: Authorization Number: Enter the **Authorization Number** from the Provider Authorization

Field 6: Service Code: Enter the **Service Code** from the Provider Authorization.

Field 7: Service From Date: Enter the date service provision began for this billing (month, day, year).

Field 8: Service Thru Date: Enter the date service provision ended for this billing (month, day, year).

Field 9: Frequency: Enter the frequency being billed for the client, which is shown under **Authorized Units and Rates** on the Provider Authorization.

Field 10: Units: Enter the number of units per frequency actually provided

Field 11: Unit Rate: Enter the rate per unit per frequency. which is shown under **Authorized Units and Rates** on the Provider Authorization.

Field 12: Total Charge: Enter the total charge for services provided which equals units provided times rate per unit.

Field 13: Customer Obligation:

Child Care Only - Enter the family fee from the Provider Authorization. This is the amount the parent/caretaker is responsible for paying per family.

Personal Assistance Services Only - Enter the amount the customer is obligated to pay. This is the amount the individual you are serving is responsible for paying.

Developmentally Disabled Community Support Adult Waiver Only - Enter the amount the customer is obligated to pay. This is the amount the individual you are serving is responsible for paying.

Field 14: Net Charge: Enter the net charge that equals the Total Charge minus the family fee.

Field 15: Provider/Preparer Signature: The signature of the provider or preparer to authorize billing to be submitted for payment. **Field 16: Signature Date:** Enter the date the billing document is signed.

Field 17: Service Approval Signature: To be signed by the service approval worker of HHS.

Field 18: The date the HHS worker signs for approval.

Field 19: Total Charge: Enter the total of all net charges of lines being billed.

Special Instructions:

If the information in Field 1 of this document is preprinted incorrectly, notify your social worker. Do not use the preprint until he/she has corrected the situation and given you additional information.

If the client number is incorrect in Field 4 or the client has not received services during the billing period, draw a line through the client number. Do not use the billing for any other client or alter any of the present information.

If there is no charge for a client for this billing period, leave the line blank. It will appear on our next billing document as long as the client is eligible to receive services.

Disposition:

Submit copies 1 and 2 for billing. 3rd copy is for provider file.



N-FOCUS HEALTH AND HUMAN SERVICES BILLING DOCUMENT
 *All billings must be received within ninety (90) days of service provision

Claim Number:

1. PROVIDER INFORMATION

(A) Office No.:		(B) Office Name:		(C) HHS Provider ID:		(D) Owner Tax No.:													
(E) Provider Name				(F) Phone Number:				Ext.											
2. Ln	3. Client Name	4. Client ID Number	5. Authoriz. Number	6. Service Code	7. Service From Date	8. Service Thru Date	9. Freq	10. Units	11. Rate	12. Total Charge	13. Cust Oblig	14. HHS Charge	15. Provider/Preparer Signature (see notice on reverse side)		16. Signature Date	17. Service Approval Signature	18. Approval Date	19. Total HHS Charge	
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