



N-FOCUS BILLING DOCUMENT

All billings must be received within ninety (90) days of service provision

CLAIM NUMBER: 00000000



Date:					DHHS Provider ID:							
Office No:		Office Name:			Phone Number:							
Provider Name:					By signing this form, the claimant certifies that the information contained in this claim is accurate and all services provided were in compliance with Department of Health and Human Services Nebraska Administrative Codes 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 representation herein are true and complete, and that no additional payment will be claimed.							
Ln	Client Name	Client ID Number	Authoriz. Number	Service Code	Service From Date	Service Thru Date	Freq	Units	Rate	Total Charge	Cust Oblig	DHHS Charge
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
Provider/Preparer Signature			Signature Date		Service Approval Signature				Approval Date		Total DHHS Charge	