



Provider Record of Services

This Record of Services is a legal document completed by you to record the dates and units of service provided. Both the provider and the client must sign and date this record verifying the accuracy of this information. A description of services provided must be recorded daily and the total units noted. This Record of Services with the billing document must be submitted within 90 days of services and can be submitted semi-monthly or monthly. The Provider is responsible for keeping records for six years.

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 representations herein are true and complete, and that no additional payment will be claimed.

Client's Name:				Client's ID Number:				Provider Name:			
Month:		Year: 2016		Service Codes:				1113: In Home Respite 5665: In-Home CLDS 9704 – Hab Day Care (child) 2500 – In-Home Hab Day Care (child) 3447- PERS 7395: Out of Home Respite 9539: Out-of-Home CLDS 7599 – Homemaker (child) 6700 – In-Home Homemaker (child)			

Line	Date	Service Code	Time In	Time Out	Frequency	Units	Rate	Total	Description Of Service
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

Frequency	Units Billed By Service Codes									
	1113	2500	3447	5665	6700	7395	7599	9539	9704	
Hour	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Month	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Day	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Occurrence	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL CLAIM AMOUNT									\$	-

I hereby certify that the above hours/days are correct and accurate and understand that fraudulent claims may result in prosecution.

 Signature of Individual Providing Services Provider Number Date Client/Guardian Signature Date

Send or deliver the signed Record of Services to the Service Coordination office or any DHHS office.