

**RECORD OF HEALTH COST -  
SHARE OF COST - MEDICAID PROGRAM  
Department of Health and Human Services**

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
ATTENTION: CLAIMS PROCESSING  
FINANCE AND SUPPORT  
PO BOX 95026  
LINCOLN, NE 68111

Month of Eligibility Month _____ Year _____	
Share of Cost (Excess - Income) The amount you must pay or obligate is \$	Replacement Form YES   NO

**FIELD #1**

**Client Address:**

Office/ Phone

**FIELD #2**

**MEDICAL/DENTAL EXPENSES OF FAMILY MEMBERS LISTED BELOW MAY BE USED TO MEET SHARE OF COST**

Medicaid ID#(A)	Name	Birthdate Mo. Day Year	Sex	SSN	HIC or RR #	INS

**PLEASE READ THE INSTRUCTIONS ON THE BACK BEFORE COMPLETING  
DECLARATION OF PROVIDER:** Each Service listed below has been provided by me to the person listed on the date specified. I, the signed provider, hereby declare that I received payment or will seek payment from the patient for the amount shown in the "Client's Share of Cost" column and that I will not accept payment from Medicaid for that amount. I also understand and agree that I may seek payment from Medicaid for the costs of my services in excess of the amount billed to the patient, up to the medical reimbursement rate. I understand that the amount to be reimbursed by insurance or any other third party, including medicare, for the service rendered cannot be listed on this form. I certify under penalty of perjury under the laws of the State of Nebraska that the foregoing is true and correct. (See back for example)

**FIELD #3**

1	Medicaid ID Nbr (See (A) Above)	Procedure/RX #	From _____ To _____ Month Day Year Month Day Year			Service Description
	Provider NPI/Medicaid Number	TAXONOMY	ZIP+4	Total Billed	Client Share of Cost	
	Provider Name		Provider Signature or Authorized Rep/Date			
2	Medicaid ID Nbr (See (A) Above)	Procedure/RX #	From _____ To _____ Month Day Year Month Day Year			Service Description
	Provider NPI/Medicaid Number	TAXONOMY	ZIP+4	Total Billed	Client Share of Cost	
	Provider Name		Provider Signature or Authorized Rep/Date			
3	Medicaid ID Nbr (See (A) Above)	Procedure/RX #	From _____ To _____ Month Day Year Month Day Year			Service Description
	Provider NPI/Medicaid Number	TAXONOMY	ZIP+4	Total Billed	Client Share of Cost	
	Provider Name		Provider Signature or Authorized Rep/Date			

**FIELD #4**

I have read the instructions on the reverse side of this form. I agree to assume full legal responsibility for the amounts listed in the "Clients Share of Cost" column.

X \_\_\_\_\_

Signature of Client or Responsible Party Date Signed

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Signature of Client or Responsible Party \_\_\_\_\_  
Date Signed

# INSTRUCTIONS FOR RECORD OF HEALTH SHARE OF COST FORM

## INSTRUCTIONS TO PROVIDER:

Use this Share of Cost form to record services, paid or obligated, which have been provided to clients (see below, example FIELD #3) in the CURRENT MONTH ONLY, the month listed in FIELD #1 or attach a medical bill that provides the same information.

E X A M P L E	Medicaid ID Nbr (See (A) Above) (1)	Procedure/RX # (2)	Service Dates (3)				Service Description (4)
			From	To			
			Month   Day   Year	Month   Day   Year			
	Provider NPI/Medicaid Number (5)	TAXONOMY (6)	ZIP+4 (7)		Total Billed (8)		Client Share of Cost (9)
	Provider Name (10)		Provider Signature or Authorized Rep/Date (10)				

1. Enter only medical/dental expenses for family members listed on the top of the form. Enter the Medicaid ID number which corresponds to the family member(s) receiving services. Some clients such as parents of Medicaid children or spouses of Medicaid aged or disabled will not be Medicaid eligible but their medical expenses count toward the share of cost.
2. Enter information in both the "PROCEDURE/RX#" and "SERVICE DESCRIPTION" boxes. Each service/Prescription must be on a separate line. Additional forms may be obtained from the DHHS office.
3. The "SERVICE DATE" boxes should be filled in with the date the service was provided. (MM/DD/CCYY)
4. Brief description of service, e.g. OFFICE VISIT, OUT PATIENT, PRESCRIPTION, etc.
5. If you are a Nebraska Medicaid Healthcare provider, enter your 10-digit NPI in the box labeled "Provider NPI/Medicaid Number", if you are an Atypical (Not Eligible for NPI) provider enter your 11-digit number. If you are not an Enrolled Medicaid provider enter your license number or Federal tax number.
6. If you are a Nebraska Medicaid Healthcare provider, enter your 10-digit Taxonomy code in the box labeled "TAXONOMY". If you are an atypical provider or not a Medicaid provider, leave this field BLANK.
7. Enter the complete 9-digit ZIP+4 of your billing address in the field labeled "ZIP+4".
8. The total of the "TOTAL BILLED" is total bill including insurance.
9. Do not include in the "CLIENT SHARE OF COST" box the amount to be reimbursed by insurance or any third party including Medicare, for service rendered. The client share of cost is the amount the client is responsible for the service rendered, it should not exceed Share of Cost amount shown at the top of the form.
10. Provider Name, Provider or Authorized representative signature. Signature stamp or typewritten signature will be accepted.
11. Please complete all items to avoid delay in processing or rejection of the form by the State. If the client needs additional forms to meet their share of cost, you may supply them if you have them on hand or contact the local DHHS office for additional forms.
12. Please submit the white copy of this form with your billing document if the Share of Cost has been met, or mail separately if a billing document is not appropriate. Department of Health and Human Services, P.O. Box 95026, Lincoln, Nebraska 68509, Attention: Claims Processing.
13. If you have any questions about how to complete this form, call Medicaid Inquiry at 1-877-255-3092, Monday through Friday, 8 a.m. to 5 p.m. Central Time.

## INSTRUCTIONS FOR THE CLIENT:

1. When you receive this form, read and sign it, take it to medical providers as you receive medical services in the month noted in FIELD #1. Keep the pink copy of your records and proof that your cost share has been met for the month in question. The provider that provides the last service necessary to meet your share of cost will send the white copy to DHHS and keep the Gold copy for his/her records.
2. For services that you received before this month, DO NOT USE THIS FORM.
3. For services received this month, either have your provider fill out this form or attach medical bills to this form.
4. At the top of the other side of this form in FIELD #1 is a box labeled "SHARE OF COST". The amount shown in this box is the amount you must pay your provider(s) or agree to pay toward your medical/dental bills before Medicaid will pay. Medical expenses for any family member shown on this form can be used to meet the share of cost. DO NOT SEND CASH OR CHECKS TO THE LOCAL OFFICE OF THE DEPARTMENT.
5. Take this form to any provider from whom you receive medical/dental services (e.g. doctor, dentist, pharmacist, hospital, etc.) in the month specified. The provider will fill in the amount you paid or have agreed to pay. YOU SHOULD NOT PAY OR AGREE TO PAY MORE THAN THE AMOUNT SHOWN IN THE "SHARE OF COST" BOX. YOU ARE RESPONSIBLE FOR THE ENTIRE AMOUNT SHOWN IN THE "CLIENT SHARE OF COST" COLUMN. Once the share of cost is met, allow the provider to mail the white copy of the form to the Department.
6. If all the provider boxes on this form have been used and you have not paid or obligated your Share of Cost, call the Automated Voice Response System (VRU) at 1-800-383-4278.
7. When you have met your Share of Cost it is your responsibility to let medical provider(s) know that you are Medicaid qualified. Use your copy of this completed form to show providers that you have met your share of cost and are Medicaid qualified for the month listed in FIELD #1. (NOTE: Medical claims will not be accepted until this form has been processed and case eligibility updated).
8. For information regarding the status of your case, call the Automated Voice Response System (VRU) at 1-800-383-4278.