PROVIDER OF CARE CLAIM FORM

Regional Center of The East Bay, Inc.
500 Davis Street, Suite 100
San Leandro, CA 94577
PH: (510) 383-1200 / (510) 618-6100
Fax: (510) 618-7770

BILLING DATE

Page

VENDOR NO.

INVOICE NUMBER

NAME

SERVICE CODE

ADDRESS

BUDGET CATEGORY

ACCOUNT CODE

PHONE No.

LINE NO. CLIENT I.D. CLIENT NAME AUTH NO. AUTHORIZED FROM - TO	BILLED SERVICES FROM - THRU	SUBCODE	GROSS BILLING		TOTAL	RECEIVED REVENUES	REV CODE	NET BILLING
			UNITS	COST/UNIT				
				TOTALS		NET CLAIM		

PLEASE MAKE COPY FOR YOUR RECORDS

Bills received after the 2nd working day of the month may not be processed until the following month. Billings for services must be submitted within 45 days after the month of service to preclude delay in payment.

PLEASE COMPLETE REVERSE SIDE. FAILURE TO DO SO COULD DELAY PAYMENT.

I certify that the consumer(s) listed above were provided the service as authorized for the stated periods, and that no additional charges were made to other parties. These claims are submitted under penalty of perjury in accordance with the terms and conditions on the reverse side of this form.

VENDOR SIGNATURE TITLE DATE

ATTENDANCE RECORD ABBREVIATIONS

PRESENT:	K	PAID HOLIDAY:	H
ABSENT:	A	CLOSED:	C
VACATION:	V	HOSPITALIZATION:	S

HOURLY RATE OF REIMBURSEMENT

INDICATE NUMBER OF HOURS SERVICES WERE PROVIDED EACH DAY

NAME ______________________________

	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

NAME ______________________________

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NAME ______________________________

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NAME ______________________________

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NAME ______________________________

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NAME ______________________________

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NAME ______________________________

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CERTIFICATION STATEMENT

1. The Provider agrees and shall certify under penalty of perjury that all claims for services provided to regional center clients have been provided to the clients by the Provider.

2. The services were, to the best of the Provider's knowledge, provided in accordance with the client's written Individual Program Plan.

3. The Provider shall also certify that all information submitted to the regional center is accurate and complete.

4. The Provider understands that payment of these claims will be from federal and/or state funds and any falsification or concealment of a material fact may be prosecuted under federal and/or state laws.

5. The Provider agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client.

6. The Provider agrees to furnish these records and any information regarding payments claimed for providing the services on request within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Developmental Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives.

7. The Provider also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.