north dakota department of human services

Instructions for Completing the HCBS and DD Billing Form
SFN 1730

Step- by -Step Instructions to fill out the SFN 1730 billing form:

1	**Provider Number** - Enter the seven-digit provider number you were given when you enrolled. **You cannot use your old five digit QSP number**. If you do, you the claim will be denied.
2	**Provider** - Enter your name. **LAST NAME** first, then your first name, and middle initial, if used.
3	**Billing Period** - You can only bill for one month at a time. Always enter the first day and the last day of the month that you provided services to a client. *Use two digits for the month, two digits for the day and two digits for the year. Example: January 2016 would be entered as:* ***01/01/16*** *through* ***01/31/16****.*
4	**Recipient's (Client) Identification (ID) Number** - Enter the "Recipient (Client) Identification Number" as it appears on the Authorization to Provide Services form. "**Authorized**" means you have received an Authorization to Provide Services form SFN 1699 and/or SFN 663 from the HCBS/County Case Manager.
5	**Recipient's (Client) Name (Last, First, Middle Initial)** - Enter the **LAST NAME**, first name and middle initial of your client (if used). Their name must be spelled the same as on the Authorization to Provide Services form you received from the HCBS/County Case Manager. Do not use nicknames (Example: Jim for James).
	➢ A separate billing form must be used for **each** client you are billing for. ➢ **Only one month of service can be billed on each billing form. If you are billing for services provided to the same person during two (2) different months, you must use two separate forms. Do not staple the forms together.**
6	**Procedure Code** - Enter the Procedure Code for the service you provided to your client. All 5 boxes must be filled. For example, 00010 is how you would bill for homemaker services.

Note: All codes can now be billed on one form if you are billing under the same recipient (client) ID number.

- Services provided in 15-minute billing units, such as homemaker service and personal care T1019 must be billed by the day. *{Example: If homemaker or personal care T1019*

services were provided to your client on 10 different days during the month, you need to enter that procedure code 10 times on 10 different lines on the billing form.}

- Services billed at a DAILY rate, such as family home care, can be billed as a single entry **if there was no break in providing services during the month**.

- The form allows 17 entries per client. If your client received care on more than 17 days during the month, use another form to enter the data. All client and provider information **MUST BE** re-entered on the second form. Do not staple the forms together.

7	**From Day** - Enter the two-digit number for the day of the month you provided services to your client on each line being billed. {Example: June 2 would be entered as "02".}
8	**Through Day** - Enter the two-digit number for the day of the month you provided services to your client on each line being billed. {Example: June 2 would be entered as "02".}
	➢ If the service is paid in 15-minute units, the "From Day" and the "Through Day" will be the same in both columns. ➢ If the service is paid using a daily rate, such as family home care, enter the first day of service in the "From Day" column and the last day of continuous service in the "Through Day" column.
9	**Units** - Enter the number of units you are billing for that day. The number of units will always be a whole number. **Never** use a decimal point on the billing form. {Example: 3 units are entered as 3} 
10	**Billed Amount** - The billed amount equals the rate for each procedure code multiplied by the number of units provided on that date. Your rate will be on the Authorization to Provide Services form(s) (SFN 1699 and/or SFN 663) that you received from the HCBS/County Case Manager.
11	Original Claim Number: Void Replacement Boxes - **Do not enter anything in these boxes when billing. Leave it blank. This section is only used to void or replace claims.** See the SFN 1730 Claims Correction Instructions if you need to void or replace a claim.
12	**Sign and date** the billing form. **You must make a copy for your records.**

Questions?

Contact the HCBS office before you send the claim. Call 1-800-755-2604 and choose option #5

Things You Need to Know Before You Bill:

These instructions will help you fill out a billing form so you can get paid for providing services to clients who qualify for:

- North Dakota Medicaid Waivers (HCBS, DD & Technology Dependent)
- Medicaid State Plan Personal Care Services
- Service Payments for the Elderly and Disabled (SPED) Program
- Expanded SPED Program

Authorization to Provide Services:

You may only bill for authorized services that you actually provided to your client. "Authorized" means you have received an Authorization to Provide Services form SFN 1699 and/or SFN 663 from the HCBS/County Case Manager.

Mailing Your Billing Forms

Billing forms should be sent in during the first few working days of the month after you have provided services to your client. Billing forms should only be submitted once a month. **If you submit claims more than once per month, your payment may be delayed because HCBS staff need enough time to process paperwork that impacts claims payment.**

- Allow at least 2-5 working days for mail to reach the State Office.

Due to large claims volume, you may not receive a check the first week of the month. To check the status of your payment, you may call 1-866-768-2435 or 701- 328-2466 on Tuesdays.

Mail Completed Billing Forms to:
N.D. Department of Human Services
Medical Services Division
ATTN: HCBS Billing Form
600 E Boulevard Ave Dept. 325
Bismarck, ND 58505-0250

Remittance Advice (RA):

You will receive a Remittance Advice (RA) in the mail each time a claim is processed. If payment is made, a check will be sent to you or deposited directly into your bank account. If you don't get paid, the RA will explain why the claim was reduced or denied. If you have questions about your RA contact the ND Health Enterprise MMIS call center at 877-328-7098.

If a claim or a part of a claim was denied/not paid and you believe the action was wrong, re-bill for the denied claim or the part that was denied/not paid. If the amount PAID was reduced from

the amount you requested and you believe the action was wrong, use the SFN 1730 billing form to make corrections. See the SFN 1730 Claim Correction Instructions to void or replace a claim.

Additional Billing Forms

Do not make your own photocopies of the blank billing forms because they may be rejected by the scanner. If you need more blank billing forms they are available at your County Social Service office or they are available on eforms at http://www.nd.gov/eforms/.

The Department sends a supply of preprinted billing forms to active providers every 6 months. The preprinted forms have your name on each one as well as the name and ID number of the client(s) you provide services for. Complete the preprinted billing forms using the steps listed on page 1 of this letter. When you are no longer providing care to a client whose name is listed on the preprinted billing form, do not use the form for any other client. **Throw it away.**

10397

HOME & COMMUNITY BASED CARE FOR THE ELDERLY/DISABLED AND DEVELOPMENTALLY DISABLED BILLING FORM

North Dakota Department of Human Services
SFN 1730

1 **Provider Number**

2 **Provider Name** (Last, First, MI)

3 **Billing Period:** M M / D D / Y Y Y Y through M M / D D / Y Y Y Y

4 **Recipient ID Number**

5 **Recipient Name (Last, First, MI)**

6 Procedure Code	7 From Day		8 Through Day		9 Units	10 Billed Amount
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.
		TH		TH		.

Providers: Retain a copy for your records.

11 **Use only when correcting claim** **Original Claim Number:**

☐ **Void**
☐ **Replacement**

Certification and Agreement of Providers: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and accept, as payment in full, the amounts paid, and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable federal or state laws. That the services herein charged were actually rendered and were rendered under the conditions specified; and that no part of such bill, claim, account or demand has been paid. That the services provided and billed for qualify for federal participation under 42 USC 1396 (A) ET. SEQ. and that rules and regulations promulgated and adopted thereunder. I further certify that goods and services hereby designated are furnished without discrimination as to age, sex, race, color, national origin, political affiliation or handicap. I agree to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the state plan and to furnish the state agency with such information, regarding any payments claimed by such person or institution forproviding services under the state plan, as the state agency may from time to time request.

12 Provider Signature: _____ Date: _____