PROVIDER OF CARE CLAIM FORM

Provider of Care Copy

San Diego Regional Center
FOR THE DEVELOPMENTALLY DISABLED
4355 RUFFIN ROAD, SUITE205, SAN DIEGO, CA 92123
(858) 576-2996

A SERVICE OF
San Diego-Imperial Counties Developmental Services, Inc.

VENDOR NO.

NAME
ADDRESS

PHONE No.

BILLING DATE
INVOICE NUMBER
SERVICE CODE
BUDGET CATEGORY
ACCOUNT CODE

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

Bills received after 8:00AM on the 4th working day of the month will not be processed until the 2nd pay run.

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

I certify that the consumers(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.

PLEASE MAKE COPY FOR YOUR RECORDS

VENDOR SIGNATURE **TITLE** **DATE**

CERTIFICATION STATEMENT

1. **The provider agrees and shall certify under penalty of perjury that all claims for service provided to regional center clients have 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 certifies 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 by federal and/or state law.**
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.**

ATTENDANCE SHEET

CLIENT NAMES Last/First	1	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	TOTAL UNITS

Certified Correct:

Preparer/Care Provider **Date**