10397

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

North Dakota Department of Health and Human Services

SFN 1730 (9-2025)

Billing Period:

M M / D D / Y Y Y Y

through

M M / D D / Y Y Y Y

Provider Number

Provider Name (Last, First, MI)

Recipient ID Number

Recipient Name (Last, First, MI)

Procedure Code	From Day		Through Day	Units	Billed Amount
		TH			.
		TH			.
		TH			.
		TH			.
		TH			.
		TH			.
		TH			.
		TH			.
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		TH			.
		TH			.
		TH			.
		TH			.

Providers: Retain a copy for your records.

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.

Provider Signature: _____ Date: _____