RI MEDICAL ASSISTANCE PROGRAM

WAIVER/REHAB CLAIM FORM

PLEASE TYPE OR PRINT CLEARLY. ONLY **BLACK** OR **BLUE** INK CAN BE PROCESSED.

LINE	RECIPIENT NUMBER / PATIENT NAME LAST | FIRST	PRIMARY DIAGNOSIS / SECONDARY DIAGNOSIS	PROCEDURE CODE / MODS 1 | 2 | 3	LOC	PATIENT LIABILITY	FROM DATE MM | DD | YY	THRU DATE	OI IND.	OI CODE	OI AMOUNT	UNITS	RATE	CHARGE
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													

TOTAL OI		TOTAL CHARGE

BILLING PROVIDER NUMBER _____

BILLING PROVIDER NAME _____

BILLING TAXONOMY _____

PERFORMING PROVIDER NUMBER _____

PERFORMING PROVIDER NAME _____

PERFORMING TAXONOMY _____

ICD IND_____

RETURN ORIGINAL TO:

WAIVER/REHAB

HP ENTERPRISE SVCS

P.O. BOX 2010

WARWICK, RI 02887

HP COPY

CERTIFICATION

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

PROVIDER SIGNATURE _____ DATE _____

INTERNAL CONTROL NUMBER MEDICAL ASSISTANCE USE ONLY