

Ohio Department of Medicaid
ICF IID PAYMENT REQUEST

1. Medicaid Billing Number (12 digits)	12. DATE MEDICAID VENDOR PAYMENT TO START			MONTH	DAY	YEAR
2. Patient/Resident Name (Last, First, MI.)	13. Transferred From Another Facility, Enter Medicaid Provider Number (7 digits) _____					
3. National Providers Identifier (NPI)	14. Medicaid Vendor Payment End Date <i>Check One and Indicate Date</i> <i>(Medicaid Does NOT Reimburse for Day of Death)</i>					
4. Level of Care Effective Date	<input type="checkbox"/> Date Transferred to Another ____ / ____ / ____	<input type="checkbox"/> Date Returned to Community ____ / ____ / ____	<input type="checkbox"/> Date Deceased ____ / ____ / ____			
FACILITY INFORMATION	Transferred To Facility <i>Medicaid Provider Number (7 digits)</i> _____	<input type="checkbox"/> Date Medicare Began to Pay ____ / ____ / ____	<input type="checkbox"/> Other (Explain Below) ____ / ____ / ____			
	5. Medicaid Provider Number	16. Patient Liability				
6. Facility Name	17. Submitted For Payment Cycle			____	0	1
7. Address (Street, City, Zip)	Adjustments	Begin Date A	End Date B	Totals C	Adjustment Code D	
	17. Days					
	18. Patient Liability			\$		
8. County	19. Patient Liability			\$		
9. Facility Type <input type="checkbox"/> ICF/MR	20. Leave Days			Total Days Used To Date		
10. Contact Person	21. Co-Insurance			\$		
11. Telephone Number ()	22. Deductible			\$		
	23. Other					
24. Explanation:			25. <input type="checkbox"/> State Hearing			
			Decision Date of State Hearing			
			____ / ____ / ____			
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	