Department of Health & Human Services
DHHS
NEBRASKA

Nebraska Department of Health and Human Services
BILLING DOCUMENT

Check One:
☐ Disabled Persons and Family Support Program
☐ Lifespan Respite Subsidy Program

Office Use Only
CFS-22 ID #:

Client Name:	Client ID #:	Client Phone #:	
Parent/Legal Guardian/Conservator/Authorized Representative: (One name only)	Client Email Address:		
Client Mailing Address: ☐ **Check if the address has changed since last payment made**	City:	State:	Zip:

Provider (Name of person providing the service)	Provider Email Address:		
Provider Mailing Address: ☐ **Check if the address has changed since last payment made**	City:	State:	Zip:

Payee: (Name of person to be paid)	Payee ID#: (# listed on check stub or EFT Notice)	If NEW payee, a Social Security # or a Federal Tax ID# is required:

Person to be paid is the: (check one)
☐ Provider ☐ Client ☐ Parent ☐ Legal Guardian ☐ Conservator ☐ Authorized Representative

INSTRUCTIONS: Submit one Billing Document per month for each provider.
Bills must be submitted within 60 days of the date of service.

AUTHORIZED SERVICE PERFORMED List below one of the following services: Respite Personal Care Housekeeping Mileage (for medical care only) and Incontinence/Medical Supplies	**DATES** List date of service separately (Include month, day, year)	**TOTAL NUMBER OF:** List the number of hours, days, miles, or meals for each service (Specify hours, days or miles after each number)	**COST** List the amount charged per hour, day or mile	**TOTAL AMOUNT**
		TOTAL BILLED		

The Client/Parent/Guardian/Conservator/Authorized Representative must verify that this billing is accurate.
For Businesses, a W-9 form will be required if you are a new provider, have an address change or a name change.
Anyone who files a false claim may be prosecuted for Fraud.

Provider Signature:	Provider Phone #	Date: (on/before client signature)
Adult Client/Parent/Legal Guardian/Conservator/Authorized Representative's Signature		Date: (on/after last date of service)

Billing documents will be returned if the provider signs and dates after the client/authorized representative.

Submit completed and signed billing document to:
DHHS.CFS22@nebraska.gov OR Department of Health & Human Services
Division of Children & Family Services, Economic Assistance
CFS-22 Payment Reviewer
P.O. Box 95026
Lincoln, NE 68509-5026

Distribution: WHITE - DHHS Central Office; YELLOW - Payee