



**WEEKLY BILLING  
FOR HOME NURSING**

**DIVISION OF SPECIALIZED CARE  
FOR CHILDREN**

1. PROVIDER NAME

2. PROVIDER NUMBER

3. PROVIDER INVOICE NO.

4. PROVIDER BILLING ADDRESS

5. CITY, STATE, ZIP

6. CHILD'S NAME (FIRST, MI, LAST)

7. SITE ADDRESS (CITY, STATE, ZIP)

8. PRIOR APPROVAL

9. RECIPIENT NUMBER

10. DSCC NUMBER

11. BIRTHDATE

**12. SERVICE SECTIONS**

PROCEDURE DESCRIPTION

PROC CODE

MODIFIERS

DATE OF SERVICE

UNITS/QTY

INSURANCE AMT

PROVIDER CHARGE

REPEAT

PROCEDURE DESCRIPTION

PROC CODE

MODIFIERS

DATE OF SERVICE

UNITS/QTY

INSURANCE AMT

PROVIDER CHARGE

REPEAT

PROCEDURE DESCRIPTION

PROC CODE

MODIFIERS

DATE OF SERVICE

UNITS/QTY

INSURANCE AMT

PROVIDER CHARGE

REPEAT

PROCEDURE DESCRIPTION

PROC CODE

MODIFIERS

DATE OF SERVICE

UNITS/QTY

INSURANCE AMT

PROVIDER CHARGE

REPEAT

PROCEDURE DESCRIPTION

PROC CODE

MODIFIERS

DATE OF SERVICE

UNITS/QTY

INSURANCE AMT

PROVIDER CHARGE

REPEAT

PROCEDURE DESCRIPTION

PROC CODE

MODIFIERS

DATE OF SERVICE

UNITS/QTY

INSURANCE AMT

PROVIDER CHARGE

REPEAT

PROCEDURE DESCRIPTION

PROC CODE

MODIFIERS

DATE OF SERVICE

UNITS/QTY

INSURANCE AMT

PROVIDER CHARGE

REPEAT

PROCEDURE DESCRIPTION

PROC CODE

MODIFIERS

DATE OF SERVICE

UNITS/QTY

INSURANCE AMT

PROVIDER CHARGE

**15. CERTIFICATION:**

By signature I certify the above billing is an accurate report of service hours rendered and hourly rates billed are in accordance with the Medical Plan of Care approved by Illinois Department of Healthcare and Family Services. All services billed were provided by nurses with a valid Illinois license or home health aide certified by the State of Illinois. Verification of services billed must be documented through the time sheets and nursing notes which must be maintained by your Agency for review upon request.

Signature

Date

13. TOTAL CHARGES

14. TOTAL DEDUCTIONS

**SEE REVERSE SIDE FOR INSTRUCTIONS**

**PLEASE FORWARD ALL BILLINGS, INSURANCE CARRIER'S EXPLANATION OF BENEFITS AND QUESTIONS TO:**

Division of Specialized Care for Children  
 Claims Processing Unit  
 3135 Old Jacksonville Road  
 Springfield, Illinois 62704-6488

Toll Free ..... (877) 791-5170  
 Fax ..... (217) 558-0773  
 Springfield Area.... (217) 558-2350  
 TTY ..... (217) 785-4728

**GENERAL BILLING INSTRUCTIONS:**

Division of Specialized Care for Children (DSCC) requires claims be received no later than twelve (12) months following the provision of services including insurance payment or denial information. Claims not received within this time frame will not be eligible for payment by DSCC and the patient, patient's family or guardian shall have no liability for payment thereof.

Dates of service billed should be in accordance with the nursing agency billing week.

The normal billing day is considered to be midnight to midnight. Nursing hours are to be reported on the calendar day they are worked. EXAMPLE: When a shift is from 11:00 p.m. to 7:00 a.m., 11:00 p.m. to midnight time must be listed on one calendar day and the remaining hours reported on the following calendar day.

Billing rates cannot exceed the rates approved by the Department of Healthcare and Family Services (DHFS). Requests for changes in the hourly rate must be submitted in writing to the DSCC care coordinator for submission to DHFS for consideration.

The nursing agency or family is responsible for submitting claims to the insurance company. Payment for approved nursing services in accordance with the Medical Plan of Care for children shall not be made until insurance has paid or rejected the claim.

Claims should be submitted along with a copy of the insurance carrier's Explanation of Benefits (EOB) as soon as insurance determination has been received. Claims where insurance payments exceed the rates approved by DHFS will be considered paid in full.

Verification of services billed must be documented and signed by the client and nurse or home health aide and maintained by your agency for review upon request.

Verify all information and calculations are correct as errors will cause a delay in the payment of a provider's claim.

**"WEEKLY BILLING FOR HOME NURSING" INSTRUCTIONS:**

Please type or computer print all claims. More than one billing form may be required to submit all charges for the nursing agency billing week.

- Provider Name:** Enter the provider's name exactly as it appears on the DHFS Provider Information Sheet.
- Provider Number:** Enter the twelve digit Provider Key Number exactly as it appears on DHFS Provider Information Sheet.
- Provider Invoice No.:** Enter up to ten numbers or letters used in your billing system for claim identification. If this field is completed it will print on DSCC's Provider Explanation of Benefit returned to you.
- Provider Billing Address:** Enter the billing street address for the agency. (This is the address where payment will be sent.)
- City, State, Zip:** Enter city, state and zip code of "Provider Billing Address" above.
- Child's Name (First, MI, Last):** Enter the child's name for services being billed
- Provider Site Address (City, State, Zip):** Enter site address, city, state and zip code where the Provider is located.
- Prior Approval:** Leave blank.
- Recipient Number:** Enter the nine digit HFS recipient number assigned to the child. Use no punctuation or spaces.
- DSCC Number:** Enter the six digit DSCC case number assigned to the child.
- Birthdate:** Enter the child's month, day and year of birth. Use the MMDDYY format.
- Service Sections:**
  - Procedure Description* – Enter description of the service performed.
  - Proc Code* – Enter the five-digit procedure code for service being billed.
  - Modifiers* – Enter the appropriate alpha code to identify the type of nursing hours for respite or training hours.
  - Date of Service* – Enter the date the service was performed. Use MMDDYY format.
  - Units/Qty* – Enter the total number of 15-minute units worked per day. Combined units of all nursing levels (RN, LPN, HHA) cannot exceed 96 units per day.
  - Insurance Amt* – Enter the amount paid by insurance for date of service as indicated on insurance carrier's EOB. Insurance carrier EOB must be attached
  - Provider Charge* – Enter the total charge for individual date of service. Do not deduct any insurance payments in this area.
- Total Charges:** Enter the total charge for the billing form.
- Total Deductions:** Enter total insurance benefits paid applicable to the billing period. Insurance EOB must be attached.
- Certification:** Signature of person certifying the billing form and date signed.

**Repeat Box:** Enter "X" to repeat information. The repeat indicator may be used to minimize repeated information in the Service Sections. The date of service must be entered in every service section.

**PROCEDURES CODES:**

HCPC CODE	MODIFIER	DESCRIPTION	UNITS/MAX UNITS
T1002		Regular RN	15 minute each unit / max 96 units per day
T1003		Regular LPN	15 minute each unit / max 96 units per day
T1004		Regular HHA	15 minute each unit / max 96 units per day
T1005	TD	Respite RN	15 minute each unit / max 96 units per day
T1005	TE	Respite LPN	15 minute each unit / max 96 units per day
S5150		Respite HHA	15 minute each unit / max 96 units per day
S5116	TD	Training RN	15 minute each unit / max 96 units per day
S5116	TE	Training LPN	15 minute each unit / max 96 units per day
T2027		Day Care	15 minute each unit / max 96 units per day