

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

FIDUCIARY USE ONLY

**ACQUIRED BRAIN INJURY (ABI)
INVOICE AND TIME SHEET**

Diagnosis Code: _____
 Date Received: ___/___/___
 Date Returned: ___/___/___
 Date Billed: ___/___/___

PART I. - PROVIDER/PARTICIPANT INFORMATION

Provider/Agency Name (First, Middle, Last)		Employee(s) Who Provided Service	
Address		Provider Type and ID (Check One) <input type="checkbox"/> AGENCY - enter FEIN _____ <input type="checkbox"/> PRIVATE - enter SSN ___/___/___	
Waiver Participant Name (First, Middle, Last)		Participant Medicaid ID Number	Provider Telephone #
		0 0	_____

PART II. - INVOICE (To be completed by all providers)

Date of Service FROM			Date of Service TO			Place of Service	Svs Type	Service Description	Procedure Code	Diagnosis Code	Days or Units	Charges \$
M	D	Y	M	D	Y							
							9					\$
							9					\$
							9					\$
							9					\$
							9					\$
TOTAL											\$	

PART III. - TIME SHEET (Complete this time sheet only if you are a provider for whom the fiduciary agent will be handling FICA, FUTA, etc.) IF YOU ARE REQUIRED TO COMPLETE THIS TIME SHEET, YOU MUST OBTAIN THE WAIVER PARTICIPANT'S SIGNATURE BELOW.

Day	Date Mo/Day/Yr	Time IN	Time OUT	Time IN	Time OUT	Time IN	Time OUT	Total Hours for Day
Mon								
Tues								
Wed								
Thur								
Fri								
Sat								
Sun								
TOTAL								

Day	Date Mo/Day/Yr	Time IN	Time OUT	Time IN	Time OUT	Time IN	Time OUT	Total Hours for Day
Mon								
Tues								
Wed								
Thur								
Fri								
Sat								
Sun								
TOTAL								

I certify that I or the individual(s) named above performed the stated ABI waiver services in accordance with the participant's approved plan.

Provider Name (Printed) _____ Signature _____

Date _____

Waiver Participant Name (Printed) _____ Signature _____

Date _____