HEALTH AGENCY INVOICE

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

HFS USE ONLY

ELITE PICA — TYPEWRITER ALIGNMENT — ELITE PICA

USE CAPITAL LETTERS ONLY

PPP

1. Provider Name | 2. Provider Number | 3. Payee | 4. | 5. | 6. Acc./Inj. | 7. Provider Reference

8. Provider Street | 9. Facility & City where Service Rendered | 10. Prior Approval

11. Provider City | State | Zip | 12. Referring Practitioner Name (First. Last) | 13. Ref. Prac. No.

14. Recipient Name (First, MI, Last) | 15. Recipient Number | 16. Birthdate | 17. H.Kids | 18. | 19. Cr. Child. | 20. | 21. Billing Date

22. Primary Diagnosis | 23. Prefix | 24. Diag. Code

25. Secondary Diagnosis | 26. Prefix | 27. Diag. Code

28. SERVICE SECTIONS

	Repeat	Procedure Description	Procedure Code	Delete	Date of Service	Cat. Serv.	Place of Serv.	Units		TPL Code	Status	TPL Amount	TPL Date	Provider Charge
1												$		$
2												$		$
3												$		$
4												$		$
5												$		$
6												$		$
7												$		$

29.

30. Sect. # | TPL Code | Status | TPL Amount | Adjudication Date | Total Charge

Sect. # | TPL Code | Status | TPL Amount | Adjudication Date | Total Deductions

Sect. # | TPL Code | Status | TPL Amount | Adjudication Date | Net Charge

31. # Sects. | 32. Original DCN | 33. Orig. Voucher #

Uncoded TPL Name

My signature certifies that; all entries on this claim are true, accurate and complete; the State's Medical Assistance Program pricing limits will be accepted as payment in full; any payments received from the patient or any other third party will be properly credited or paid to the Illinois Department of Healthcare and Family Services; records necessary to fully disclose the nature and extent of services provided are maintained and will be made available upon request of State and Federal officials responsible for the various aspects of the State's Medical Assistance Program, as provided under Title XIX of the Social Security Act and applicable State statutes; I am duly authorized as a representative of the entity to be reimbursed by this claim; I understand payment is made from State and Federal funds and that any falsification or concealment of material fact may lead to appropriate legal action; in compliance with the Civil Rights Act of 1964, services were provided without discrimination on the grounds of race, color or national origin; and handicapped persons are afforded the rights and considerations specified in Section 504 of the Rehabilitation Act of 1973 and Part 84 of the Code of Federal Regulations.

Completion mandatory, 305 ILCS 5/1-1 et. seq. penalty non-payment, Form Approved by the Forms Management center.

Provider Signature _____ Date _____

HFS 2212 (R-2-15)

IL 478-1021

1A 1B PROOF 1 8810027732

FACE; SCREEN 5% & 10%