

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Child Care

PROVIDER BILLING FORM

These fields will be completed when you receive your Provider Billing Form (PBF) each month.

The Individual ID number is a computer generated number.

Billing Period From: **10/01/2007** To: **10/31/2007** Provider Name: _____ Provider Phone Number: _____
 CLR Number: _____ County: _____ Provider Type: _____

Individual ID: 0121080604 Child Name: Doe, Johnny

October	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
Scheduled	01	01	01	01	01	01	01	01	01	01	01	01			01	01	01	01	01	01			01	01	01	01	01		01	01	01			
Exceptions																																		02

Individual ID: 0121080604 Child Name: Dough, Cookie

October	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
Scheduled	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02	02		
Exceptions																																		60

Individual ID: 0121080604 Child Name: Goodboy, Joey

October	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
Scheduled	02	02	02	02	01				02	02	02	02	01		02	02	02	02	01	01		02	02	02	02	01		02	02	02	02		
Exceptions																																	02

I certify that all entries have been made by me or reviewed by me for accuracy, and are complete and true to the best of my knowledge. I understand that if I give false information or withhold information, I may be subject to prosecution for fraud. I understand and agree that if an overpayment occurs for any reason, I am required to pay back any money I received in error. I understand that the information that I have provided on this form is subject to verification by federal, state, or local officials to determine if it is true. I also give my consent to the Department for Community Based Services or its designee to make any necessary contact to verify my statements or gain additional information, including on-site inspections of attendance records.

Provider signature _____ Title _____ Date _____

This area is for use by DCC or designee only. Total PBF amount \$ _____

In the exception line, you will only fill in days that differed from the printed schedule.

Codes shown in the Example
 01 – Full Day
 02 – Part Day
 60 – Terminated Care

There are other codes that will be used based on the provider type. The list of codes will be shown on the cover letter that you will receive with each PBF.

