MONTGOMERY COUNTY INTELLECTUAL DISABILITIES
INVOICING PROCEDURES

Updated:  September 26, 2005

Header Information

<table>
<thead>
<tr>
<th>CODE</th>
<th>ITEM</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Invoice Number</td>
<td>County use only.</td>
</tr>
<tr>
<td>B</td>
<td>Vendor Number</td>
<td>Six digit number (see latest contract Exhibit B).</td>
</tr>
<tr>
<td>C</td>
<td>Facility Number</td>
<td>Twelve digit number (see latest contract Exhibit B).</td>
</tr>
<tr>
<td>D</td>
<td>Month/Year</td>
<td>Enter month and year of service as formatted.</td>
</tr>
<tr>
<td>E</td>
<td>Page</td>
<td>Enter current page “of” total pages.</td>
</tr>
<tr>
<td>F</td>
<td>Waiver Prov. #</td>
<td>Enter Waiver Provider Number on invoices containing waiver consumers. Can be found on your signed Medicare agreement.</td>
</tr>
<tr>
<td>G</td>
<td>Service Code</td>
<td>Four digit cost center code, same as last four digits of facility number (see latest contract Exhibit B).</td>
</tr>
<tr>
<td>H</td>
<td>Provider Name</td>
<td>Enter your provider name.</td>
</tr>
<tr>
<td>I</td>
<td>Address (Provider)</td>
<td>Enter your provider address.</td>
</tr>
<tr>
<td>J</td>
<td>Facility Name</td>
<td>Enter name of facility if applicable, or re-enter facility #.</td>
</tr>
<tr>
<td>K</td>
<td>Address (Fac.)</td>
<td>Enter address of facility.</td>
</tr>
<tr>
<td>L</td>
<td>Contact Person</td>
<td>Enter the name of provider personnel whom should be contacted regarding this invoice.</td>
</tr>
<tr>
<td>M</td>
<td>Telephone Number</td>
<td>Enter the telephone number of provider personnel whom should be contacted regarding this invoice.</td>
</tr>
</tbody>
</table>

Body Information

(1) Name of Consumer Enter last name of consumer only.
(2) BSU # Enter 10 digit BSU number WITHOUT hyphen.
(3) Dates of Service Enter “first day served” – “last day served” within the Month.
(4) Transaction Code Enter five digit alpha-numeric transaction code (see latest contract Exhibit B).
(4a) Info Modifier Enter two digit information modifier if applicable. If not, please leave blank.
(5) Rate Enter CURRENT, APPROVED contract rate only (see latest contract Exhibit B).
(6) # of Units Enter number of units being invoiced for, NO FRACTIONAL UNITS are allowed.
(7) County Program Enter “net” total dollars being invoiced for ( = 5 x 6 ).
(8) Room & Board Enter consumer’s room & board amount when applicable.
(9) Liability Enter consumer’s liability amount when applicable.
Body Information (continued)

(10) Other
Enter any other non county funding where applicable.
Require pre-approval from Montgomery County.

(11) Total Dollars
Enter total consumers expenditures \( ( = 7 + 8 + 9 + 10 - 12 ) \).

(12) Ineligible
Amount not eligible for DPW participation.

(13) Other Inc Defined
Enter abbreviated identifier such as MA(medical Assistance), DON(donation), INS(Insurance), etc…

General Information

- Billing should be completed monthly and dates of service should not span months. Invoices are due twenty (20) days after the month end.

- Providers are responsible for re-invoicing for services denied for non-authorized clients, or amounts that exceed the limits set forth in the respective contract.

- Be sure to complete the “Page Total” line for columns seven (7) to twelve (12), for each page, and “Grand Total” on the last page of invoice. Also, have the certification line signed by the appropriate personnel on the “Grand Total” page.

- Do not mix different service codes, submit a separate invoice for each service code.

- Please use a separate page for each facility under one service code. A summary invoice may be used to invoice several facilities under one service code, on one invoice. The only information to enter differently when filling out the summary invoice is:
  
  - Facility number (C) should read “SUMMARY”.
  - Facility name (L) and address (M) should read “SUMMARY”.
  - Column (1) should contain the facility number, and column (2) should contain the facility name where applicable.

Summary invoices needing multiple pages should have line “Page Total” completed for each page, “Grand Total” completed on the last page, and the certification line signed by the appropriate personnel on the “Grand Total” page.

- Please use invoice labeled EARLY INTERVENTION for early intervention invoices. Note that there are no Room and Board or Client Liability columns. Instead enter Medical Assistance and any possible “Other” third party incomes for Early Intervention.
General Information (continued)

- Please use invoice labeled PRIVATE LICENSED FACILITY for private licensed facilities (PLF’s). Be sure to note that rates are gross and third party revenue (columns eight (8) to ten (10)) is deducted from PROGRAM TOTAL, column seven (7) to calculate NET DOLLARS. ( 7 - 8 - 9 - 10 -12 = 11 ).

- Invoices should be completed using the CURRENT, APPROVED facility numbers, service codes, procedure codes and modifier if applicable, and rates found on Exhibit B of the executed contract. **Invoices containing information that does not fall within the parameters of Exhibit B of the current executed contract will be returned unprocessed. Also, invoices submitted on the wrong form, submitted incomplete, and/or incorrect will be returned.**

- Please submit all invoice **ONLY** to the following attention and address:

  Attention: Fiscal Office – Invoices  
  Montgomery County Human Services Center  
  MH/MR/D&A/BH Fiscal Office  
  1430 DeKalb Pike; PO Box 311  
  Norristown, PA 19404-0311

Invoices addressed in any other manner will delay or prevent payment.