State of Oklahoma
Department of Human Services

Service/Attendance/Claim Record

For the month of _____ , _____

Facility name				County	
Name	Last	First	MI	Date of birth	Case number

Services received during days in attendance

	Transportation	Meals	Nursing	Medical supervisor	Activities			Personal Care				Psychosocial								Therapy								Hours per day	Charge code	Hourly charge amount
					Recreation	Exercise	Health Ed.	Eating	Toileting	Transferring	Grooming	Social Services		Reality Orientation		Other	Therapy	Interaction		Nutrition Counseling		P.T.		O.T.		Speech				
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Charge code	Units		Amount		Charges
D. Daily	_____	x	$ _____	=	_____
H. Hourly	_____	x	$ _____	=	_____
		Total charges		=	_____
Total amount paid by client				=	$ _____
Total billed					$ _____

I certify the above record of hours is true and correct.

This is to certify that the billing information is true and complete. The reimbursement to be received does not exceed the usual and customary charges made to the general public. In addition, I certify that I will seek payment from the client for the amount shown on the Notification of Eligibility, provided by the Oklahoma Department of Human Services. I understand that any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable State or Federal law.

_____
Signature of client, caretaker, family member, or guardian

_____
Signature of provider representative