Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care

Private Duty Nurse Claim Form

1. Patient's Name:

2. Patient's Medicaid Number: | ID #:

3. Referring:

a. Physician's Name:

b. Physician's NPI:

4. ICD Indicator
☐ ICD-9 ☐ ICD-10

5. Primary Diagnosis Code:

6	Date of Service		Place of Service	Procedure Code	DX Code	Charges	Units	Prior Authorization Number
	From:	To:						
A			12					
B			12					
C			12					
D			12					
E			12					
F			12					
			7. Total Charges					
			8. Amount Paid By / Or Due From Client					
			9. Balance Due					

SIGNATURE OF PROVIDER: I certify that (1) the services listed on this claim were medically indicated and necessary to the health of this patient and were personally rendered by me; (2) the charges for such services are just, unpaid, actually due according to law and program policy and not in excess of regular fees and, that no charge, in addition to line 7, will be made; (3) the information provided on this claim is true, accurate and complete. I agree to comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I understand that payment and satisfaction of this claim will be from Federal and/or State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

10. Date | 11. Signature of Provider
SIGN HERE

Mail to:

DHHS - 5th Floor
PO Box 95026
Lincoln, NE 68509-5026
Attention: Medicaid Claims Unit

12. Provider NPI: | Taxonomy:

13. Provider Name:

Address:

City: | State | Zip +

Telephone Number (include area code)

If New Address ☐ check here | Starting Date:

Distribution: Part One - DHHS Medicaid Payments; Part Two - Provider Copy

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(Previous Version 12/11 should NOT be used)