

STATE OF MONTANA - DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

FOR USE BY NURSING FACILITIES

PLEASE TYPE OR PRINT

FORM NO. MA-3

NURSING FACILITY – NAME AND ADDRESS		PROV. INFORMATION	MAIL TO MONTANA MEDICAID DEPT. MA-3 P.O. BOX 8000 HELENA, MT 59604 TELEPHONE NUMBER 1-800-624-3958							
1 PATIENT: LAST NAME		FIRST	MIDDLE INITIAL	M <input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> SEX		COUNTY	INDIVIDUAL NUMBER		AUTH.	
DIAGNOSIS		DIAG. CODE		DATE OF BIRTH		DATE ADMITTED		STATEMENT PERIOD		
				MO. DAY YEAR		MO. DAY YEAR		MO FROM DAY YEAR		MO. TO DAY YEAR
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES		(LESS) PERSONAL RESOURCES		NET CHARGES
								→		
2 PATIENT: LAST NAME		FIRST	MIDDLE INITIAL	M <input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> SEX		COUNTY	INDIVIDUAL NUMBER		AUTH.	
DIAGNOSIS		DIAG. CODE		DATE OF BIRTH		DATE ADMITTED		STATEMENT PERIOD		
				MO. DAY YEAR		MO. DAY YEAR		MO FROM DAY YEAR		MO. TO DAY YEAR
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES		(LESS) PERSONAL RESOURCES		NET CHARGES
								→		
3 PATIENT: LAST NAME		FIRST	MIDDLE INITIAL	M <input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> SEX		COUNTY	INDIVIDUAL NUMBER		AUTH.	
DIAGNOSIS		DIAG. CODE		DATE OF BIRTH		DATE ADMITTED		STATEMENT PERIOD		
				MO. DAY YEAR		MO. DAY YEAR		MO FROM DAY YEAR		MO. TO DAY YEAR
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES		(LESS) PERSONAL RESOURCES		NET CHARGES
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4 PATIENT: LAST NAME		FIRST	MIDDLE INITIAL	M <input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> SEX		COUNTY	INDIVIDUAL NUMBER		AUTH.	
DIAGNOSIS		DIAG. CODE		DATE OF BIRTH		DATE ADMITTED		STATEMENT PERIOD		
				MO. DAY YEAR		MO. DAY YEAR		MO FROM DAY YEAR		MO. TO DAY YEAR
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES		(LESS) PERSONAL RESOURCES		NET CHARGES
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5 PATIENT: LAST NAME		FIRST	MIDDLE INITIAL	M <input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> SEX		COUNTY	INDIVIDUAL NUMBER		AUTH.	
DIAGNOSIS		DIAG. CODE		DATE OF BIRTH		DATE ADMITTED		STATEMENT PERIOD		
				MO. DAY YEAR		MO. DAY YEAR		MO FROM DAY YEAR		MO. TO DAY YEAR
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6 PATIENT: LAST NAME		FIRST	MIDDLE INITIAL	M <input type="checkbox"/> S <input type="checkbox"/> F <input type="checkbox"/> SEX		COUNTY	INDIVIDUAL NUMBER		AUTH.	
DIAGNOSIS		DIAG. CODE		DATE OF BIRTH		DATE ADMITTED		STATEMENT PERIOD		
				MO. DAY YEAR		MO. DAY YEAR		MO FROM DAY YEAR		MO. TO DAY YEAR
NEW DIAGNOSIS/RECENT COMPLICATIONS		DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES		(LESS) PERSONAL RESOURCES		NET CHARGES
								→		

I hereby certify that the care, services and supplies itemized have been furnished, the amounts listed are due and, except as noted, no part thereof has been paid; payment of fees made in accordance with established schedules is accepted as payment in full. I further certify that the service(s) indicated above has/have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap. I hereby agree to maintain and furnish on request to the Department, the Montana Medicaid Fraud Control Bureau, the U.S. DHHS, the Comptroller General of the U.S., or any of their duly authorized agents or representatives such records as necessary to disclose fully the extent of care, services, and supplies provided to individuals under the Montana Medical Assistance Program.

I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS. I hereby agree to comply with all rules and requirements pertaining to the Montana Medicaid Program, including but not limited to, Title XIX of the Social Security Act, Montana Statutes and the Administrative Rules of Montana.

TOTAL CHARGES THIS SHEET	
TOTAL CHARGES THIS MONTH	

PROVIDER'S SIGNATURE _____ DATE _____