MONTANA HEALTHCARE PROGRAMS

Form MA-3

For Use by Nursing Homes

Mail Completed Form to: Montana Medicaid, DEPT. MA-3, P.O. Box 0000, Helena, MT 59604

NURSING HOME NAME:	PROVIDER INFORMATION:
ADDRESS:	
CITY/STATE/ZIP:	

1	PATIENT LAST NAME / FIRST NAME / MI		Sex F M	COUNTY	INDIVIDUAL NUMBER	AUTH			
	DIAGNOSIS / DIAG. CODE		DATE OF BIRTH MM DD YY	DATE ADMITTED MM DD YY	STATEMENT FROM MM DD YY	PERIOD TO MM DD YY			
	NEW DIAGNOSIS/RECENT COMPLICATIONS / DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(Less) PERSONAL RESOURCES	NET CHARGES		
						----------→			
2	PATIENT LAST NAME / FIRST NAME / MI		Sex F M	COUNTY	INDIVIDUAL NUMBER	AUTH			
	DIAGNOSIS / DIAG. CODE		DATE OF BIRTH MM DD YY	DATE ADMITTED MM DD YY	STATEMENT FROM MM DD YY	PERIOD TO MM DD YY			
	NEW DIAGNOSIS/RECENT COMPLICATIONS / DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(Less) PERSONAL RESOURCES	NET CHARGES		
						----------→			
3	PATIENT LAST NAME / FIRST NAME / MI		Sex F M	COUNTY	INDIVIDUAL NUMBER	AUTH			
	DIAGNOSIS / DIAG. CODE		DATE OF BIRTH MM DD YY	DATE ADMITTED MM DD YY	STATEMENT FROM MM DD YY	PERIOD TO MM DD YY			
	NEW DIAGNOSIS/RECENT COMPLICATIONS / DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(Less) PERSONAL RESOURCES	NET CHARGES		
						----------→			
4	PATIENT LAST NAME / FIRST NAME / MI		Sex F M	COUNTY	INDIVIDUAL NUMBER	AUTH			
	DIAGNOSIS / DIAG. CODE		DATE OF BIRTH MM DD YY	DATE ADMITTED MM DD YY	STATEMENT FROM MM DD YY	PERIOD TO MM DD YY			
	NEW DIAGNOSIS/RECENT COMPLICATIONS / DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(Less) PERSONAL RESOURCES	NET CHARGES		
						----------→			
5	PATIENT LAST NAME / FIRST NAME / MI		Sex F M	COUNTY	INDIVIDUAL NUMBER	AUTH			
	DIAGNOSIS / DIAG. CODE		DATE OF BIRTH MM DD YY	DATE ADMITTED MM DD YY	STATEMENT FROM MM DD YY	PERIOD TO MM DD YY			
	NEW DIAGNOSIS/RECENT COMPLICATIONS / DIAG. CODE		NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(Less) PERSONAL RESOURCES	NET CHARGES		
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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 Medlca1d 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 are 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 PROS ECUTED 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 Statues and the Administrative Rules of Montana.

TOTAL CHARGES THIS SHEET:
TOTAL CHARGES THIS MONTH:

PROVIDER SIGNATURE: DATE: