Click in area to type. Tab to move cursor.

Revised: 12/12/00

DIVISION OF MEDICAID
BILLING FORM - NURSE ASSISTANT TESTING FEES

Facility Name _____

Provider Number _____ PAGE _____ OF _____

Mailing Address _____

NAME OF NURSING ASSISTANT	SOCIAL SECURITY NUMBER	DATE EMPLOYED	DATE TESTED	TYPE OF TEST			COST OF TEST		FOR MEDICAID USE ONLY (APPROVAL)
				WRITTEN	CLINICAL	ORAL			
TOTAL AMOUNT OF THIS BILLING							$ 0.00		$

NOTE: Pass/Fail results must be attached to all billing forms when submitted.

I CERTIFY THAT ALL OF THE PERSONS LISTED ARE EMPLOYEES OF THE NAMED FACILITY AND THAT ALL OF THESES PERSONS TOOK THE NURSING ASSISTANT TEST ON THE DATE INDICATED.

_____ _____ _____

SIGNATURE TITLE DATE

FOR MEDICAID USE ONLY

Gross Amount of this Billing $ _____

Medicaid Percentage X _____ %

Amount Reimbursed by Medicaid $ _____

_____ _____

APPROVED BY DATE