Revised: 12/12/00

# DIVISION OF MEDICAID
# BILLING FORM - NURSE ASSISTANT TRAINING EXPENSES

Facility Name _____

Provider Number _____ Training Program Approval Number _____

Mailing Address _____

**TRAINING CENTER'S ONLY - INDICATE FACILITY NAME PAYMENT IS TO BE MADE UNDER**

Remit Payment To: _____

| INVOICE DATE (mm/dd/yyyy) | VENDOR NAME | DESCRIPTION | AMOUNT | FOR MEDICAID USE ONLY (APPROVAL) |
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TOTAL AMOUNT OF THIS BILLING $ 0.00 $

NOTE: Copies of invoices for the expenses listed above must be attached.

**I CERTIFY THAT ALL EXPENSES LISTED ABOVE WERE INCURRED BY THE FACILITY OR TRAINING CENTER FOR A NURSE ASSISTANT TRAINING PROGRAM.**

SIGNATURE _____ TITLE _____ DATE _____

FOR MEDICAID USE ONLY

Gross Amount of this Billing $ _____

Medicaid Percentage X _____ %

Amount Reimbursed by Medicaid $ _____

APPROVED BY _____ DATE _____