

APPENDIX F

OBRA (PASRR) MI Assessment Billing Form

Provider:	Provider Identification #:
Address:	Federal ID Number:

CLAIM FOR LEVEL II ASSESSMENT BILLING FORM

	Recipient Name	ID Number (If available)	Date of Service	Nursing Home/Facility	Charge
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
Total Charges					\$

Provider Signature _____
Date

Please Mail Form to:
Kristen Flynn
OBRA (PASRR) Coordinator
175 Lancaster Street
Portland, Maine 04101

**Note: Incomplete billing forms will delay
payment for services.**

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