Hospice Reimbursement Invoice

Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

Facility Name _____ **Medicaid Prov. ID#** _____

For the Month of _____ **Year** _____ **NF Daily Rate** _____

Please send invoice to:

Hospice _____ **Medicaid Prov. ID#** _____

Mailing Address _____

_____

Patient(s) Medicaid number	Level of Care TG (1) = Skilled TF (2) = Intermediate *(see SCDHHS Form 181 Section II Field 11. A)*	Monthly Recurring Income Amount	* Hospice Patient Daily Room and Board Rate	Number of Patient Days	Total Amount Due *(Hospice Patient Daily Room and Board Rate x Number of Hospice Days)*

_____ _____

Facility Approval Signature Authority **Date**

Please Check. NF or ICF/MR ECF must be attached

*Note: Hospice Patient's Daily Rate is determined by subtracting the patient's Recurring Income Amount divided by the number of days in the billing month from the Nursing Facility daily rate.