CLAIM FOR SUPPORT OF CHILDREN
Payable from Family and Children Funds
State Form 28808 (R18 / 10-17)
Approved by State Board of Accounts, 2017
INDIANA DEPARTMENT OF CHILD SERVICES

1. Name of vendor	2. Last four digits of Tax ID/SSN	3. ST number	4. Invoice number	5. Date of invoice
6. Address (*number and street, city, state, and ZIP code*)	7. Invoice Type ☐ First Bill ☐ Rate Adjust ☐ Re-Bill ☐ Appeal	8. Page 1 of ____ Pages		

9. Invoice Service Type
☐ Residential ☐ LCPA ☐ Relative ☐ Foster Parent ☐ Family Preservation ☐ Older Youth ☐ Adoption
☐ Home Builders ☐ CMHC ☐ CMHI ☐ Group ☐ Court ☐ Reports ☐ Medicaid/BX/BH

10. For the period: From: ________ , Year ______ to ________ , Year ______	11. Total of Claim $

	CHILDREN FOR WHOSE SUPPORT AND ALLOWANCES ARE DUE AND PAYABLE					DATES OF SERVICE				
	12. COUNTY	13. BILLABLE UNIT REFERRAL ID	14. CASE ID	15. COMMENTS / DOCUMENTATION / NPI NUMBER	16. BILLING CODE	17. BEGIN	18. END	19. UNIT	20. RATE	21. TOTAL COST
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Pursuant to the provisions and penalties of Indiana Code 5-11-10-1, I hereby certify that the foregoing invoice is just and correct, that the amount claimed is legally due, after allowing all just credits, and that no part of the same has been paid.									**Page Total**	

I hereby swear and affirm under the penalties of perjury the attached bill contains the actual placement and/or service costs provided for the individual listed on such bill. The dates, days, hours and units of time and costs for placement or service are true and accurate. I understand that in submitting this that I am under oath stating and affirming that these services were provided and fully understand that these services may be independently audited and that any discrepancy may be referred to a local prosecutor for criminal prosecution.

22. Signature of vendor	23. Telephone number of vendor	24. E-mail address of vendor	25. Date (*month, day, year*)

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INSTRUCTIONS FOR COMPLETING A CLAIM FOR SUPPORT OF CHILDREN

October 2017

*** = Required field.**

1. ***NAME** – Legal name of benefit/product/service provider; must match name submitted via the Vendor Information Form.
2. ***LAST FOUR DIGITS OF TAX ID** – The last four digits of the Federal Tax Identification Number associated with the legal name in Section 1. This is your Social Security Number for individuals (e.g.foster parents).
3. ***ST NUMBER** – State Vendor ID # assigned by the DCS payment system (KidTraks). This 6 digit number can be found on the Warrant Summary.
   ST Numbers are also available at https://magik.dcs.in.gov/Portal/Home/Login?ReturnUrl=%2fportal%2f. From there, select "Provider Service Guide" and enter your Tax ID in the appropriate space provided.
4. ***INVOICE NUMBER** – assigned by the vendor; **CAN BE NO LONGER THAN 8 CHARACTERS;** should be a unique number for each submission and can include letters and/or numbers (e.g. "Nov2010" or "1001").
5. ***DATE OF INVOICE** – Date assigned by the vendor as the date of the claim. Invoices must be received by DCS KidTraks Invoicing within 10 business days of this date.
6. ***ADDRESS** – Vendor's complete address, which should match the most recent Vendor Information form on file.
7. ***INVOICE TYPE** – Is the invoice being submitted the **first submission**, a **rate adjustment**, a **re-bill** due to denial of past invoice lines or an **appeal** of denied lines or services provided?
8. ***PAGE NUMBER** – Includes the current page number as well as the total number of pages included in the Claim (limited to a total of 3 pages per Invoice).
9. ***INVOICE SERVICE TYPE** – Only one overriding service type should be picked for all sevice codes being invoice in column 16. The invoice service type should reflect all services being invoiced.
10. ***FOR THE PERIOD** – The beginning and end dates of the month being billed on the Claim. (e.g. January services would be: From January 1, 2011 to January 31, 2011).
    The Claim period should not be confused with the Dates of Service (Sections 17 and 18) as vendors may list multiple children/Case #s/Referral IDs with different dates of service during the Claim period.
11. ***TOTAL OF CLAIM** – The cumulative sum of the Total Cost columns (col. 21) of all invoice pages carried-out 2 digits. This is the total cost of all (up to 3) of the invoice pages.
    This total cannot be adjusted upward once it's been submitted.
12. ***COUNTY** – Name of County that authorized services to be rendered for the child being served. For *Post Adoption or Independent Living services, please enter County of child's residence.*
    NOTE: An invoice can include line items for multiple counties.
13. ***BILLABLE UNIT REFERRAL ID**– Billable Unit Referral ID (PL# or RF#) for Service Referrals; Probation will still use Case number until fully implemented on the Referral Wizard.
14. ***CASE ID** – This is the case number in KidTraks and is required for all foster care invoices as well as all provider invoices for all services.
15. ***COMMENTS / DOCUMENTATION / NPI NUMBER** – Spaces can also be used to provide explanation / documentation to support payments and NPI number of doctor.
16. ***BILLING CODE** – Includes both Service and Component Codes for the benefit/product/service provided. Provider codes are available at https://magik.dcs.in.gov/Portal/Home/Login?ReturnUrl=%2fportal%2f
    From there, select "Provider Service Guide" and enter your Tax ID or DCS Vendor ID (i.e. ST Number) in the appropriate space provided.
17. ***BEGIN DATE OF SERVICE** – First day the benefit/product/service was provided. If the service was provided in one day, the Begin Date and End Dates will be the same.
18. ***END OF DATE OF SERVICE** – Last day the benefit/product/service was provided. If the service was provided in one day, the Begin Date and End Dates will be the same.
19. ***UNIT** – The number of times a benefit/product/service was rendered during the Claim period.
    Units are defined in contracts/agreements and are typically 15-minute or 1-hour increments for services such as counseling; days for residential and intensive reunification services.
20. ***RATE** – The amount (carried-out 2 digits) per unit for which a benefit/product/service is rendered per the contract/agreement.
21. ***TOTAL COST** – The total amount of the line item calculated by multiplying the number of units by the rate (Unit x Rate=Total Cost) carried-out 2 digits.
22. ***SIGNATURE OF VENDOR** – Authorizing signature of vendor submitting the Claim. All pages submitted must be signed; blue ink is strongly recommended.
23. *** TELEPHONE NUMBER OF VENDOR** – Telephone number for Vendor, to be used only for clarifications and resolution of billing issues.
24. ***E-MAIL ADDRESS OF VENDOR** – E-mail address of authorizing vendor submitting the Claim. Provider e-mail address should be to fiscal staff who can respond to questions/issues.
25. ***DATE** – This is the date the invoice was completed/signed. This date can not be before the last day of service.