Absolute HCBS, LLC Individual Client Billing Document

AHCCCS ID#: 440374

Provider Name: Provider ID#: Billing Cycle:

Member Name: Member Medicaid ID:

Date	Start Time	Verification	End Time	Verification	Service Type	Total Hours	Approval Initial

MEMBER/HEALTH CARE DECISION MAKER, OR DESIGNEE SIGNATURE

SIGNER PRINTED NAME (IF NOT MEMBER)

EMPLOYEE SIGNATURE

MANAGER SIGNATURE

Do not initial and/or sign until after services have been provided. By Signing, the provider and responsible party certify the hours of service are correct. Services can only be provided to the individual listed on the authorization form. Company is not responsible to pay for services provided in excess of those authorized for this individual. Use blue or black ink to sign. Do not use white out and/or cross out information.