



## San Diego Regional Center

*Serving Individuals with Developmental Disabilities in San Diego and Imperial Counties*

4355 Ruffin Road, San Diego, California 92123 • (858) 576-2996 • [www.sdrc.org](http://www.sdrc.org)

March 30, 2020

Dear Service Providers:

The following instructions are for billing absences due to COVID-19. Billing for regular attendance is done as usual.

Providers will need to fill out the attached **Provider of Care Claim form** to bill SDRC for the total absences related to COVID-19. The form needs to include; vendor number, vendor name, vendor address, service code, and billing date.

Please complete the following sections of the Provider of Care Claim form:

- **Line No. Client I.D.:** fill in the phrase “**Billing as outlined in State of Emergency.**”
- **Billed Services from – thru:** Date range is March 4, 2020 – March 31, 2020. Absences prior to the March 4, 2020 State of Emergency can’t be billed.
- **Gross Billing:** Enter the total number of absence units you are billing for your program. You will not need to fill out each client you are submitting absences for.

Include with the completed form the supporting documentation showing your calculations for the allowed billable absences for each client. The supporting documentation needs to follow SDRC Billing Guidelines for COVID-19 State of Emergency dated March 16, 2020. Please sign and date page 1 of the provider care claim form before submitting to SDRC.

Submit all invoices and documentation by mail or e-mail.

- **Email:** [askpos@sdrc.org](mailto:askpos@sdrc.org). The subject line needs to state “COVID-19 Billing” along with the vendor number.
- **Mail:** 4355 Ruffin Road, Suite 119 San Diego, CA 92123.

If you have any billing questions, please contact [askpos@sdrc.org](mailto:askpos@sdrc.org).

Thank you.

# PROVIDER OF CARE CLAIM FORM

Provider of Care Copy

**San Diego Regional Center**  
 FOR THE DEVELOPMENTALLY DISABLED  
 4355 RUFFIN ROAD, SUITE 205, SAN DIEGO, CA 92123  
 (858) 576-2996

A SERVICE OF  
 San Diego-Imperial Counties Developmental Services, Inc.

VENDOR NO.

BILLING DATE

INVOICE NUMBER

NAME  
 ADDRESS

SERVICE CODE

BUDGET CATEGORY  
 ACCOUNT CODE

PHONE No.

LINE NO. AUTH NO.	CLIENT I.D. CLIENT NAME AUTHORIZED FROM -	BILLED SERVICES FROM - THRU	SUBCODE	GROSS BILLING		TOTAL	RECEIVED REVENUES	REV CODE	NET BILLING
				UNITS	COST/UNIT				
<b>TOTALS</b>							<b>NET CLAIM</b>		

Bills received after 8:00AM on the 4th working day of the month will not be processed until the 2nd pay run.

**PLEASE COMPLETE REVERSE SIDE. FAILURE TO DO SO  
 COULD DELAY PAYMENT.**

I certify that the consumers(s) listed above were provided the service as authorized for the stated periods, and that no additional charges were made to other parties. These claims are submitted under penalty of perjury in accordance with the terms and conditions on the reverse side of this form.

**PLEASE MAKE COPY FOR YOUR RECORDS**



VENDOR SIGNATURE

TITLE

DATE

## CERTIFICATION STATEMENT

1. The provider agrees and shall certify under penalty of perjury that all claims for service provided to regional center clients have provided to the clients by the Provider.
2. The services were, to the best of the Provider's knowledge, provided in accordance with the client's written Individual Program Plan.
3. The Provider certifies that all information submitted to the regional center is accurate and complete.
4. The Provider understands that payment of these claims will be from federal and/or state funds, and any falsification or concealment of a material fact may be prosecuted by federal and/or state law.
5. The Provider agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client.
6. The Provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Developmental Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives.
7. The Provider also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

### ATTENDANCE SHEET

CLIENT NAMES Last/First	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL UNITS