Ohio Department of Developmental Disabilities
Medicaid Billing System
Roster of Services Delivered

MM YY Month and Year of Service Delivered	Contract Number
Recipient's Last Name [1st 5 letters] First Initial	Recipient's Medicaid Number

Date of Service	Service Code	Units of Service	Other Source	Other Source Amount	Group/Staff Size	Service County 4 letters	Usual Customary Rate
				$.	/		$.
				$.	/		$.
				$.	/		$.
				$.	/		$.
				$.	/		$.
				$.	/		$.
				$.	/		$.

Contractor name	Contractor Phone Number
Contractor Address	

Contractor Certification

This is to certify that I have rendered the above Medicaid services to the recipient indicated. The HCBS Waiver Services were rendered in accordance with the recipient's approved ISP and are within the limits specified on the recipients DODD PAWS for HCBS Waiver Services form, as applicable. I understand that payment for all Medicaid Services will be from Federal and/or State funds & that any false claims, statements, documents of concealments of a material fact may be prosecuted under applicable Federal or State Laws.

Signature of Medicaid Provider	Date