Personal care provider supplement invoice

Michigan Coordinated Health – Adult Foster Care and Homes for the Aged

Enrollee information

First name:	Last name:	
Medicaid ID number:		
Street address:		
City:	State:	ZIP code:
Date of birth (MM/DD/YYYY):	Gender:	

Services rendered

Dates of care (MM/DD/YYYY):	to:
Amount charged: $	Current monthly rate: $250.92

Payment information

AFC/HFA home, organization or personal care provider name:		
AFC/HFA owned by: ☐ Individual ☐ Organization		
National Provider Identification (NPI) number:		
Tax identification number (TIN):		
Street address for payment:		
City:	State:	ZIP code:
AFC/HFA home, organization or personal care provider phone number:		
Personal care services (PCS) provider signature:		**Date:**

By signing this invoice, you attest that you and/or your organization provided personal care services to the enrollee during the specified time frame based on the enrollee's apparent eligibility for those services.

United Healthcare® Community Plan