Skilled Nursing Facility Quality Assurance Fee – (FY09)
Payment Invoice for August 1, 2009 to August 31, 2009

Department of Health Care Services
Accounting Section/Cashiers Unit Mail Stop 1101
1501 Capitol Ave., Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Please add OSHPD and NPI number along with facility's name address and contact information when making a payment.

OSHPD Number:

NPI Number:

Due Date: 10/31/2009

Total Remitted: $_____

NPI	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
	5650	000	00	H	125600	31	85214	A09	0001

Total Resident Days_____ Multiply by $11.16 = Total Amount Due _____

Original Signature _____ Date _____

Please Print Name _____ Contact Phone no. _____ E-mail_____

(Please remit the total amount along with this payment Invoice by due date above)
PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions:

Total Resident Days - Enter the Facility's Total Resident Days for the Month that is listed on the Payment Invoice. This includes but is not limited to Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity and Hospice.

Total Amount Due - Multiply the Facility's Total Resident Days by $11.16 and enter that amount in the space provided for the Total Amount Due.

Total Remitted - Enter the amount of the check or money order you are sending with this invoice. This amount should be the same amount as the Total Amount Due.

Original Signature - Sign here in the space provided. Please use ink.

Date - Enter the date you completed this form.

Contact Phone No. - Enter your area code and daytime phone number and email address.

Payment Invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

Submit this completed payment invoice along with the Total Amount Due to the address above. All checks or money orders must be made out to Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the Due Date above. Failure to make the complete payment on time may result in penalties and/or a delay in the facility's license renewal.

Skilled Nursing Facility Quality Assurance Fee – (FY09)
Payment Invoice for September 1, 2009 to September 30, 2009

Department of Health Care Services
Accounting Section/Cashiers Unit Mail Stop 1101
1501 Capitol Ave., Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Please add OSHPD and NPI number along with facility's name address and contact information when making a payment.

OSHPD Number:

NPI Number:

Due Date: 10/31/2009

Total Remitted: $_____

NPI	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
	5650	000	00	H	125600	31	85214	A09	0001

Total Resident Days_____ Multiply by $11.16 = Total Amount Due _____

Original Signature _____ Date _____

Please Print Name _____ Contact Phone no. _____ E-mail_____

(Please remit the total amount along with this payment Invoice by due date above)
PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions

Total Resident Days - Enter the Facility's Total Resident Days for the Month that is listed on the Payment Invoice. This includes but is not limited to Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity and Hospice.

Total Amount Due - Multiply the Facility's Total Resident Days by $11.16 and enter that amount in the space provided for the Total Amount Due.

Total Remitted - Enter the amount of the check or money order you are sending with this invoice. This amount should be the same amount as the Total Amount Due.

Original Signature - Sign here in the space provided. Please use ink.

Date - Enter the date you completed this form.

Contact Phone No. - Enter your area code and daytime phone number and email address.

Payment Invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

Submit this completed form along with the Total Amount Due to the address above. All checks or money orders must be made out to Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the Due Date above. Failure to make the complete payment on time may result in penalties and/or a delay in the facility's license renewal.

Skilled Nursing Facility Quality Assurance Fee – (FY09)
Payment Invoice for October 1, 2009 to October 31, 2009

Department of Health Care Services
Accounting Section/Cashiers Unit Mail Stop 1101
1501 Capitol Ave., Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Please add OSHPD and NPI number along with facility's name address and contact information when making a payment.

OSHPD Number:

NPI Number:

Due Date: 11/30/2009

Total Remitted: $_____

NPI	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
	5650	000	00	H	125600	31	85214	A09	0001

Total Resident Days_____ Multiply by $11.16 = Total Amount Due _____

Original Signature _____ Date _____

Please Print Name _____ Contact Phone no. _____ E-mail_____

(Please remit the total amount along with this payment Invoice by due date above)
PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions

Total Resident Days - Enter the Facility's Total Resident Days for the Month that is listed on the Payment Invoice. This includes but is not limited to Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity and Hospice.

Total Amount Due - Amount Due. Multiply the Facility's Total Resident Days by $11.16 and enter that amount in the space provided for the Total

Total Remitted - Enter the amount of the check or money order you are sending with this invoice/ This amount should be the same amount as the Total Amount Due.

Original Signature - Sign here in space provided. Please use ink.

Date - Enter the date you completed this form.

Contact Phone No. - Enter your area code and daytime phone number and email address.

Payment Invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

Submit this completed form along with the Total Amount Due to the address above. All checks or money orders must be made out to Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the Due Date above. Failure to make the complete payment on time may result in penalties and/or a delay in the facility's license renewal.

Skilled Nursing Facility Quality Assurance Fee – (FY09)
Payment Invoice for November 1, 2009 to November 30, 2009

Department of Health Care Services
Accounting Section/Cashiers Unit Mail Stop 1101
1501 Capitol Ave., Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Please add OSHPD and NPI number along with facility's name address and contact information when making a payment.

OSHPD Number:

NPI Number:

Due Date: 12/31/2009

Total Remitted: $_____

NPI	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
	5650	000	00	H	125600	31	85214	A09	0001

Total Resident Days_____ Multiply by $11.16 = Total Amount Due _____

Original Signature _____ Date _____

Please Print Name _____ Contact Phone no. _____ E-mail_____

(Please remit the total amount along with this payment Invoice by due date above)
PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions:

Total Resident Days - Enter the Facility's Total Resident Days for the Month that is listed on the Payment Invoice. This includes but is not limited to Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity and Hospice.

Total Amount Due - Multiply the Facility's Total Resident Days by $11.16 and enter that amount in the space provided for the Total Amount Due.

Total Remitted - Enter the amount of the check or money order you are sending with this invoice. This amount should be the same amount as the Total Amount Due.

Original Signature - Sign here in the space provided. Please use ink.

Date - Enter the date you completed this form.

Contact Phone No. - Enter your area code and daytime phone number and email address.

Payment Invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

Submit this completed payment invoice along with the Total Amount Due to the address above. All checks or money orders must be made out to Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the Due Date above. Failure to make the complete payment on time may result in penalties and/or a delay in the facility's license renewal.

Skilled Nursing Facility Quality Assurance Fee – (FY09)
Payment Invoice for December 1, 2009 to December 31, 2009

Department of Health Care Services
Accounting Section/Cashiers Unit Mail Stop 1101
1501 Capitol Ave., Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Please add OSHPD and NPI number along with facility's name address and contact information when making a payment.

OSHPD Number:

NPI Number:

.Due Date: 1/31/2010

Total Remitted: $_____

NPI	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
	5650	000	00	H	125600	31	85214	A09	0001

Total Resident Days_____ Multiply by $11.16 = Total Amount Due _____

Original Signature _____ Date _____

Please Print Name _____ Contact Phone no. _____ E-mail_____

(Please remit the total amount along with this payment Invoice by due date above)
PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions

Total Resident Days - Enter the Facility's Total Resident Days for the Month that is listed on the Payment Invoice. This includes but is not limited to Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity and Hospice.

Total Amount Due - Multiply the Facility's Total Resident Days by $11.16 and enter that amount in the space provided for the Total Amount Due.

Total Remitted - Enter the amount of the check or money order you are sending with this invoice. This amount should be the same amount as the Total Amount Due.

Original Signature - Sign here in the space provided. Please use ink.

Date - Enter the date you completed this form.

Contact Phone No. - Enter your area code and daytime phone number and email address.

Payment Invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

Submit this completed form along with the Total Amount Due to the address above. All checks or money orders must be made out to Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the Due Date above. Failure to make the complete payment on time may result in penalties and/or a delay in the facility's license renewal.

Skilled Nursing Facility Quality Assurance Fee – (FY09)
Payment Invoice for January 1, 2010 to January 31, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit Mail Stop 1101
1501 Capitol Ave., Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Please add OSHPD and NPI number along with facility's name address and contact information when making a payment.

OSHPD Number:

NPI Number:

Due Date: 2/30/2010

Total Remitted: $_____

NPI	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
	5650	000	00	H	125600	31	85214	A09	0001

Total Resident Days_____ Multiply by $11.16 = Total Amount Due _____

Original Signature _____ Date _____

Please Print Name _____ Contact Phone no. _____ E-mail_____

(Please remit the total amount along with this payment Invoice by due date above)
PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions

Total Resident Days - Enter the Facility's Total Resident Days for the Month that is listed on the Payment Invoice. This includes but is not limited to Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity and Hospice.

Total Amount Due - Multiply the Facility's Total Resident Days by $11.16 and enter that amount in the space provided for the Total Amount Due.

Total Remitted - Enter the amount of the check or money order you are sending with this invoice. This amount should be the same amount as the Total Amount Due.

Original Signature - Sign here in space provided. Please use ink.

Date - Enter the date you completed this form.

Contact Phone No. - Enter your area code and daytime phone number and email address.

Payment Invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx

Submit this completed form along with the Total Amount Due to the address above. All checks or money orders must be made out to Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the Due Date above. Failure to make the complete payment on time may result in penalties and/or a delay in the facility's license renewal.

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – (FY09)
Payment Invoice for February 1, 2010 to February 28, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Office of Statewide Health Planning and Development Number:

National Provider Identifier: _____

Due Date: 3/31/2010

Amount Remitted: $_____

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A09	0001

Total Resident Days_____ Multiply by $11.16 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail_____

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions:

Total Resident Days - Enter the *Total Resident Days* for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.

Amount Due - Multiply the *Total Resident Days* by $11.16 and enter that amount in the space provided for the *Amount Due*.

Amount Remitted - Enter the amount of the check or money order you are sending with this payment invoice. This amount should be the same amount as the *Amount Due*.

Original Signature - Sign in the space provided. Please use ink.

Date - Enter the date you completed this payment invoice.

Phone Number/E-Mail - Enter your area code, daytime phone number, and E-Mail address.

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – (FY09)
Payment Invoice for March 1, 2010 to March 31, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Office of Statewide Health Planning and Development Number:

National Provider Identifier: _____

Due Date: 4/30/2010

Amount Remitted: $_____

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A09	0001

Total Resident Days_____ Multiply by $11.16 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail_____

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions:

Total Resident Days - Enter the *Total Resident Days* for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.

Amount Due - Multiply the *Total Resident Days* by $11.16 and enter that amount in the space provided for the *Amount Due*.

Amount Remitted - Enter the amount of the check or money order you are sending with this payment invoice. This amount should be the same amount as the *Amount Due*.

Original Signature - Sign in the space provided. Please use ink.

Date - Enter the date you completed this payment invoice.

Phone Number/E-Mail - Enter your area code, daytime phone number, and E-Mail address.

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – (FY09)
Payment Invoice for April 1, 2010 to April 30, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Office of Statewide Health Planning and Development Number:

National Provider Identifier: _____

Due Date: 5/31/2010

Amount Remitted: $_____

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A09	0001

Total Resident Days_____ Multiply by $11.16 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail_____

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions:

Total Resident Days - Enter the *Total Resident Days* for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.

Amount Due - Multiply the *Total Resident Days* by $11.16 and enter that amount in the space provided for the *Amount Due*.

Amount Remitted - Enter the amount of the check or money order you are sending with this payment invoice. This amount should be the same amount as the *Amount Due*.

Original Signature - Sign in the space provided. Please use ink.

Date - Enter the date you completed this payment invoice.

Phone Number/E-Mail - Enter your area code, daytime phone number, and E-Mail address.

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – (FY 10)
Payment Invoice for May 1 to May 31, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Please add OSHPD and NPI number along with facility's name address and contact information when making a payment.

Office of Statewide Health Planning and Development Number: _____

National Provider Identifier (NPI):_____

Due Date: 6/30/10

Amount Remitted: $_____

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A09	0001

Total Resident Days_____ Multiply by $11.16 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail_____

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions:

Total Resident Days - Enter the *Total Resident Days* for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.

Amount Due - Multiply the *Total Resident Days* by $11.16 and enter that amount in the space provided for the *Amount Due*.

Amount Remitted - Enter the amount of the check or money order you are sending with this payment invoice. This amount should be the same amount as the *Amount Due*.

Original Signature - Sign in the space provided. Please use ink.

Date - Enter the date you completed this payment invoice.

Phone Number/E-Mail - Enter your area code, daytime phone number, and E-Mail address.

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the NPI on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – (FY 10)
Payment Invoice for June 1 to June 30, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Please add OSHPD and NPI number along with facility's name address and contact information when making a payment.

Office of Statewide Health Planning and Development Number: _____

National Provider Identifier (NPI):_____

Due Date: 7/31/10

Amount Remitted: $_____

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A09	0001

Total Resident Days_____ Multiply by $11.16 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail_____

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions:

Total Resident Days - Enter the *Total Resident Days* for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.

Amount Due - Multiply the *Total Resident Days* by $11.16 and enter that amount in the space provided for the *Amount Due*.

Amount Remitted - Enter the amount of the check or money order you are sending with this payment invoice. This amount should be the same amount as the *Amount Due*.

Original Signature - Sign in the space provided. Please use ink.

Date - Enter the date you completed this payment invoice.

Phone Number/E-Mail - Enter your area code, daytime phone number, and E-Mail address.

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the NPI on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.

Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Level-B (FSSA/NF-B) Quality Assurance Fee – (FY 10)
Payment Invoice for July 1 to July 31, 2010

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

Please add OSHPD and NPI number along with facility's name address and contact information when making a payment.

Office of Statewide Health Planning and Development Number: _____

National Provider Identifier (NPI):_____

Due Date: 8/31/10

Amount Remitted: $_____

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
5650	000	00	H	125600	31	85214	A09	0001

Total Resident Days_____ Multiply by $11.16 = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail_____

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions:

Total Resident Days - Enter the *Total Resident Days* for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.

Amount Due - Multiply the *Total Resident Days* by $11.16 and enter that amount in the space provided for the *Amount Due*.

Amount Remitted - Enter the amount of the check or money order you are sending with this payment invoice. This amount should be the same amount as the *Amount Due*.

Original Signature - Sign in the space provided. Please use ink.

Date - Enter the date you completed this payment invoice.

Phone Number/E-Mail - Enter your area code, daytime phone number, and E-Mail address.

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the NPI on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.