

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

OSHPD Number: _____

NPI Number: _____

Due Date: 10/31/2009

Total Remitted: \$ _____

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

NPI	Index	Object Detail	Agency Object	BLK H	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

OSHPD Number:

NPI Number:

Due Date: 10/31/2009

Total Remitted: \$ _____

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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

OSHPD Number:

NPI Number:

Due Date: 11/30/2009

Total Remitted: \$ _____

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

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 _____

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

Department of Health Care Services
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1501 Capitol Ave., Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

OSHPD Number: _____

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

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

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

Department of Health Care Services
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1501 Capitol Ave., Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

OSHPD Number: _____

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

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

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

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1501 Capitol Ave., Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

OSHPD Number: _____

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

NPI Number: _____

Due Date: 2/30/2010

Total Remitted: \$ _____

NPI	Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
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