

## Purpose of Form

Form 04CB002E, CFSD Claim for Purchase of Residential Care, is used to bill the Oklahoma Department of Human Services (OKDHS), Children and Family Services Division (CFSD), for these services for youth in the custody of OKDHS:

- Levels E, D+, D, C, B, Residential Diagnostic and Evaluation services;
- Residential Maternity Services;
- Therapeutic Foster Care;
- Therapeutic Community Homes; and
- Individualized Therapeutic Services (ITS).

## Instructions for Preparation of Form

**DO NOT** reduce the size of this form or the font. **DO NOT** print form in portrait orientation. **Doing so will impede efficient and accurate claims processing.** The form is prepared by the service provider in triplicate with the **original** mailed to:

Oklahoma Department of Human Services  
Attention: CFSD Administrative Services Unit  
P. O. Box 25352  
Oklahoma City, OK 73125

The claimant retains a copy and sends a copy to the facility liaison. **Make sure the claim is complete and correct before it is submitted for payment. Incomplete or incorrect claim forms will be returned for correction, which will further delay payment.**

**Month and year:** Enter the month and year for services claimed.

**Federal employer identification number (FEI):** Enter the FEI of the facility providing the services.

**Contract number:** Enter the contract number under which the services were provided.

**Facility:** Enter the name of the facility providing the services.

**KK case number:** Enter the eight-digit OKDHS KIDS assigned case number of the youth receiving services.

**Exact case name of youth:** Enter the **exact case**, last name, first name, and middle initial, of the youth receiving services. For example, Richard Jones should not be entered as Dick Jones.

**CLAIMS MUST BE SUBMITTED WITH THE RESIDENTS LISTED IN ALPHABETICAL ORDER.**

**M, C, or D number and person code:** Enter the appropriate M, C, or D prefix and the assigned six-digit medical number, followed by a hyphen, and the assigned two-digit person code of the youth receiving services.

**Medicaid client ID number:** Enter the number assigned to the client.

**Dates of service:** Enter two digits for the first day and two digits for the last day of the month claimed. For example, 07-01 to 07-31. If the youth was admitted after the first day of the month or was discharged before the last day of the month, enter the exact dates of placement. For example, 07-10 to 07-31, for a youth admitted after the first day of the month or 07-01 to 07-21 for a youth discharged before the last day of the month. A separate claim is required for each month in which services are claimed. **Not all months have 31 days.**

**Total leave days:** Enter the total number of leave days taken by the youth during the month services are provided.

**Total number days:** Enter the total number of days services are claimed for the youth.

**Leave days:** Cross out or circle the actual dates of the month that the youth was in leave status.

**Non-utilized days:** Enter the number of days the beds were not utilized.

**Total days:** Enter the total number of days claimed for all youth provided services.

**X rate:** Enter the daily rate at which services are claimed.

**Total claimed:** Enter the total amount (total days x rate) for which services are claimed.