PGM – HAD0030
DATE

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PROSPECTIVE PAYMENTS SYSTEM
ADVANCE/BILLING DOCUMENT FOR RESIDENTIAL

PROVIDER NAME Ardmore Enterprises

MONTH/YR __________

PROVIDER NO. 301

OPERATIONAL DAYS __________

TOTAL NUMBER OF CLIENTS ______________

TOTAL ATTENDANCE DAYS ______________

TOTAL ABSENTEEISM DAYS ______________

TOTAL ALLOWABLE DAYS ______________

TOTAL NON-ALLOWABLE DAYS ______________

I HEREBY CERTIFY BY MY SIGNATURE THAT THE INFORMATION CONTAINED HEREIN IS CORRECT TO THE BEST OF MY KNOWLEDGE.

____
SIGNATURE

THIS DOCUMENT REFLECTS CLIENT DATA PROCESSED AS OF ________________