# BRAIN AND SPINAL CORD INJURY BILLING/REIMBURSEMENT FORM

	Pr	ovider	C	lient
Name: Cham	pion Home	Health Care	Patient's Name:	Medicaid No.
Billing Addro	ess: 3911 No	ewberry Rd., Ste B-2	Address:	Birth Date
City Gainesvi	ille El <b>Zin</b>	32607		Mo. Day Year
Provider Nur			CityZip_	
Provider Nur	mber 0012	134-00	Please circle service typ	pe: Rate per hr \$
Provider Tele	ephone: 352	2-371-8600	Companion Person Attendant	nal
			Other	
	Units (Hrs)	In/Onti Time Description	n of Sarvices	
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Provider Sign	ature:		Date: Remember Own Rec	to Retain Copy for You ords and Mail Original

## BRAIN AND SPINAL CORD INJURY BILLING/REIMBURSEMENT FORM

Provider		Client							
Name: Champion Home Health Ca	re	Patient's Name:	Medicaid No.  Birth Date						
Billing Address: 3911 Newberry R	ld., Ste B-2	Address:							
City Gainesville, FL Zip 32607		City Zip	Mo. Day Year						
Provider Number 0012134-00 Provider Telephone: 352-371-860	0	Please circle service type: Companion Personal Attendant Other	Rate per hr \$						
Date of Units In/Out Service (This) Thue	Description of Ser								
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Provider Signature:	Da	te: Romamber to R	etain Copy for Your						

Own Records and Mail Original

#### **COMPANION CARE**

#### Client Name:

### Provider Name: Champion Home Health Care

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Grocery																															
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Laundry																											<u> </u>				
Financial																															
Management	<u> </u>																									<u> </u>					
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Hygiene																															
Assistance	`																														
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Supervision	<u> </u>	<u></u>	<u> </u>	<u> </u>			<u> </u>	<u> </u>	<u> </u>	<u></u>	<u> </u>	<u></u>	<u> </u>	L		<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>										

CLIENT SIGNATURE	DATE	,