NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services

ATTACHMENT 5
INTERPRETER BILLING DOCUMENT

		Date:
		Interpreter Name:
		Interpreter Language:
DHHS Staff Name or Authorized Representative:	**DHHS Office Location:**	**Interpreter Street Address:**
DHHS Staff Name or Auth Rep Phone Number:	**DHHS Division:**	**Interpreter Phone Number:**

CASE INFORMATION

Client Name:	**Client Street Address:**
Client ID Number:	**Client Phone Number:**

DATE	**SERVICE DELIVERY TIME**		
	START	**FINISH**	****SUB-TOTAL HOURS**
	Cancellation Fee (if applicable)		
In Person: Total Service Hours			
In Person: Amount to be paid			**$**
Phone: Total Minutes			
Phone: Amount to be paid			**$**
Translation: Total Hours			
Translation: Amount to be paid			**$**
Total Hour Payment:			**$**

Total Invoice Payment Amount **$**

Statement:

By signing this form, the signor certifies that the information contained in this document is true, complete and accurate, and in compliance with the terms of the contract. Anyone filing a false claim may be prosecuted for fraud.

Instructions:

*Please identify whether the interpreting included in-person, over phone, and/or translation services.

**Please round total service hours to the nearest quarter hour except where not allowed per contract (medicaid funds and/or over phone).

Provider's Signature	**Date of Signature**
Provider's Printed Name	**Provider's Phone Number**
Approving Worker's Signature	**Date of Signature**
Approving Worker's Printed Name and Division	**Worker's Phone Number**

The completed billing document should be submitted to the DHHS Interpreter Billing Email Address at: dhhs.interpreterbilling@nebraska.gov.
DHHS reserves the right to not pay any initial request for payment that is submitted later than sixty (60) calendar days past the last day of the month for which services were provided.