# Guthrie Mainstream Services LLC
# Billing Coversheet

Page_____ of _____

**Provider Name:** _____ **Phone No.:**_____ **Pay Period:** _____201___
(Please print legibly)
**Address:** _____ **City:**_____ **Zip:**_____ **Field Supervisor:**_____

Change of address needs to be filed with your field supervisor.

| **Member's Name** (Alphabetical Order) | **Attendant Care** | **Habilitation** | **Respite** | **Day Treatment** | **Office Use Only** |
|---|---|---|---|---|---|

| Last Name | First Name | | ATC 1-1 | ATC 1-2 | ATC 1-3 | | HAH 1-1 | HAH 1-2 | HAH 1-3 | | RSP 1-1 | RSP 1-2 | RSP 1-3 | | DTT | DTS | | T/S Copies | ATC Copies | HAH Copies | Originals | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| **Totals:** | | | | | | | | | | | | | | | | | | | | | | |

| **Training Hours:** | **Administration Hours:** | **E-bill Hours:** |
|---|---|---|

_____ _____ _____ _____
**Provider Signature (Required)** **Date** **GMS Administration** **Date**

**The above hours are true and accurate and represent all payments due for the pay period indicated. I understand any errors on my part may result in late payment.**