HOW TO FILL OUT A TB INVOICE FORM (CO-17)

Only the following sections of a TB Invoice Form (CO-17) need to be completed.

The following information is needed for the specified section number:

8). Specify your report type as either (Y), (N), or (T). This is based on how you registered on your "W-9 IRS Form":
Individual/Sole Proprietor = (Y)
Corporation = (Y)
Medical services for Profit= (Y)
Other = (N)
Medical services for Non-profit= (N)
Town or District Health Department = (T)

9). Write in your 9-digit TAX ID number.

10). Write in NAME and ADDRESS of the Payee: where check is to be mailed. (as it appears on the registered W-9 and SP-26 NB forms).

13). Optional field - Put in any vendor/provider comments, i.e. patient account numbers, etc.

14). Give a description of goods or services, i.e. office visit, directly observed therapy visit. Dates of service and CPT code should be included in this description.

Please NOTE in this boxed area, a **SIGNATURE IS REQUIRED.**
Invoices without a signature will not be processed.

15). Quantity – List the number of each type of service performed or provided.

17). List the unit price for each service. DPH reimburses at the Medicaid rate. Current Medicaid rates for different services can be found at: www.ctdssmap.com

18). Amount – The quantity of services provided multiplied by the appropriate unit price. The total amount should be included at the bottom of this column.

****Attach any claim/s (*i.e., HICF, UB-92, etc.*) or supporting documentation to the invoice/s.****

Invoices and supporting documentation should be sent to the address at the bottom of the invoice. Please do not email any documents with patient identifying information.