

# NEW MILLENNIUM HEALTH CARE INC SERVICE MODIFICATION AGREEMENT

Client Name: \_\_\_\_\_

Client MA Number: \_\_\_\_\_

Address: \_\_\_\_\_

Admission Date: \_\_\_\_\_

Emergency Phone Number: \_\_\_\_\_

Service Provided	Discipline	Description of Services To Be Provided	Frequency units/day	Unit Cost	Payer Source
	Nursing	Private Duty RN complex	units / day	\$9.91 per unit	
	Nursing	Private Duty LPN complex	units / day	\$7.44 per unit	
	Nursing	Private Duty RN shared care	units / day	\$6.20 per unit	
	Nursing	Private Duty LPN shared care	units / day	\$4.76 per unit	
	Nursing	Private Duty RN regular care	units / day	\$8.26 per unit	
	Nursing	Private Duty LPN regular care	units / day	\$6.34 per unit	
	Nursing	RN Skilled Nursing Visit	units / day	\$71.30 per	
	Nursing	RN Supervisory PCA Visits	units / day	\$7.00 per	
	PCA	PCA	units / day	\$3.98 per unit	

Services are billed on a bi- monthly, monthly, quarterly, bi-annual or annual basis.

Client Financially Responsible for Bill:  Yes  No

If No, and other than Medical Assistance then list the responsible parties name:

\_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I request payment of any authorized health insurance benefits and hereby assign benefits payable on my behalf directly to New Millennium Health Care Inc. I understand that should payment not be made to New Millennium Health Care Inc, I will be responsible for services rendered to me.

I understand I will be responsible for :  co-insurance  deductible  private pay  none.

I understand that the charges for services reflect time for direct care, travel time, mileage reimbursement, time spent in contacting my physician, charting, written information to keep the doctor informed of my progress, supervision of cares and staff, care plan reviews, case management, care conferences, coordination with other services, medication and supply renewal, secretarial time, billing, maintenance of medical records, and for non-chargeable supplies and services.

I will be notified in writing at least fourteen days in advance of any change in charges or services

Complete Progress Note or other concerns relating to client care below.

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Home Care Nurse's Name:

\_\_\_\_\_

Signature (Client or Authorized Representative)

\_\_\_\_\_

Date

\_\_\_\_\_

Signature and Title of Witness

\_\_\_\_\_

Date