# NURSING HOME CREDIT BALANCE REPORT

Nursing Facility Name:
Medicaid Vendor Number:
National Provider Identifier:
Quarter Ending:

Contact Person:
Phone Number:
Fax Number:
E-mail Address:

| Name of Resident (Column 1) | Source of Credit (Column 2) | Medicaid Eligible Date (Column 3) | Discharge Date (Column 4) | Expiration Date (Column 5) | Service Period (Column 6) | Amount of Credit Balance (Column 7) | Date Payment Received (Column 8) | Amount Repaid (Column 9) | Date Repaid (Column 10) | Method of Payment (Column 11) | Amount Outstanding (Column 12) | Reason for Credit Balance (Column 13) | Remarks (Column 14) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |
| | | | | | | | | | | | $0.00 | | |

Signature

Printed name and title