

PURCHASE OF SERVICES PROVIDER INVOICE

DHS use only
Invoice No. _____

Agreement No. _____

Provider Name _____
(Please print or type)

Provider Addr _____

Billing Period _____ State/Local _____

County No. and Name _____
(Please print or type)

City/State _____ Zip _____

	Case Number	Last	Client's Name		M.	Service Date		Service Code	Unit Cost	No. of Units	Total Cost	Fees	Credits	Net Cost		
			First			Beginning	Ending									
01																
02																
03																
04																
05																
06																
07																
08																
09																
10																
11																
12																
I certify that the items for which payment is claimed were provided and are unpaid.																
										TOTALS						

Claimant _____ Date _____

Approval _____ Date _____