Community Rehabilitation Provider (CRP)

OKLAHOMA Rehabilitation Services

INVOICE

CRP Name: _____

CRP Address:

Phone number: _____

Email address: _____

Counselor: _____

Office location:

Individual: _____

Case ID #: _____

Invoice No.: _____

Authorization Number: _____

Authorization Begin Date:

Authorization End Date:

Counselor Email: _____

Complete information below for payment of milestone/service.

Contract: _____

Milestone/Service Start Date:

Milestone/Service End Date:

Milestone/Service :	QTY:	Hour rate:	Max Rate:	Total

Balance Due Upon Receipt

I certify I have provded the services listed on this invoice in accordance with the Employment Services Contract, Oklahoma Adminstrative Rules, the IPE and Client choice; and I have submitted all supporting documentation required pursuant to the contract and rules. Therefore, I hereby request payment for the service(s) rendered.

Submitted By: _____

Date submitted:

Comments:

Reset Form