

Community Rehabilitation Provider (CRP)



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
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I certify I have provided the services listed on this invoice in accordance with the Employment Services Contract, Oklahoma Administrative 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:

Balance Due Upon Receipt

Comments: