

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: _____

Job Start Date: _____

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
_____	_____	_____	_____	_____

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 within 90 days of the provision of services. Therefore, I hereby request payment for the service(s) rendered.

Submitted By: _____

Date submitted: _____

Comments:

Balance Due Upon Receipt

[Reset Form](#)