

REQUEST FOR PAYMENT – SOCIAL SERVICES

A. PROVIDER IDENTIFICATION			B.	CONTROL NO.	DATE
NAME					
ADDRESS					
CITY		STATE		ZIP	
PROVIDER NO.	CONTRACT NO.	BILLING FOR SERVICES PROVIDED:			
		(MO)	(YR)		

C. CLIENT IDENTIFICATION			D.						
NO	NAME OF CLIENT	CLIENT IDENTIFICATION NUMBER	INCLUSIVE DATES OF SERVICE		NO. OF UNITS	DESCRIPTION OF SERVICE OR COMMODITY	SERVICE CODE	UNIT PRICE	AMOUNT
			FROM	THRU					
1									\$ -
2									\$ -
3									\$ -
4									\$ -
5									\$ -
6									\$ -
7									\$ -
8									\$ -
9									\$ -
10									\$ -
11									\$ -
12									\$ -
13									\$ -
14									\$ -
15									\$ -
								TOTAL	\$ -

GRAND TOTAL \$ -

(FOR LOCAL OFFICE USE)

I declare and affirm under the penalties of perjury that this claim has been examined by me and to the best of my knowledge and belief is in all things true and correct I further agree to comply with the provisions of the Civil Rights Act of 1964 and regulations issued thereunder relating to nondiscrimination in Federally assisted programs.

Claimant Signature _____
Date