Provider Invoice First Page

(Use a separate invoice form for each program area checked below)

[ ] DD SERVICES [ ] ECI [ ] THE CHILDREN'S PARTNERSHIP [ ] ATCMHMR-CHILDREN'S PARTNERSHIP [ ] YAFAC

[ ] Internal Contract Provider (DD) [ ] Internal Contract Provider (CFS) [ ] Internal Contract Provider (AMH) [ ] Internal Contract Provider (SASS)

Internal Contract Provider: contracted to provide services at an ATCMHMR site or non MSO services

VENDOR INFORMATION:

Type of Provider - [ ] Family [ ] Organization [ ] Individual

*Name/ID Number*____

Address ____

____

*Telephone Number*____

Tax ID # ***or*** *Social Security #* __________________________________

FOR INTERNAL CONTRACT
SUBMIT TO:
Program/Contract
Manager at designated
ATCMHMR office

FOR DD SERVICES
SUBMIT TO:
Sharon M. Walker
ATCMHMR
5225 North Lamar
Austin, TX 78751
(512) 483-5892

FOR ECI SERVICES
SUBMIT TO:
Laurie Ruddy
ATCMHMR
1717 West 10th St.
Austin, TX 78703
(512) 804-3100

FOR CHILD & FAMILY SERVICES
SUBMIT TO:
Toni Perkins
ATCMHMR
1717 West 10th.
Austin, TX 78703
(512) 804-3172

FOR ATCMHMR OFFICE USE ONLY
*Invoice Received*__________________
*Invoice Submitted to A/P*___________
*GL Acct. No.*_____________________
*Invoice No.*______________________

Line No.	Service Date	Consumer Name if applicable	Service Code/Type	Coordinator if applicable	Ind. Prov. Name (Complete if different than vendor organization name)	Units *Unit Types: M=Month D= Day H= Hour S= Session P=Product # Units	Type* **(circle one)**	Unit Cost	Co-pay if applicable (Total per Consumer)	Line Total	Voucher #	Unit #	Fund #	Adjust.
1							M D H S P			$0.00				
2							M D H S P			$0.00				
3							M D H S P			$0.00				
4							M D H S P			$0.00				
5							M D H S P			$0.00				
6							M D H S P			$0.00				
7							M D H S P			$0.00				
8							M D H S P			$0.00				
9							M D H S P			$0.00				
10							M D H S P			$0.00				
11							M D H S P			$0.00				
12							M D H S P			$0.00				
13							M D H S P			$0.00				
14							M D H S P			$0.00				

Page Subtotal	$0.00
Less Co-pays (if applicable)	
Provider Page Total	
Adjustments:	
Approved Page Total	
INVOICE TOTAL	
Total Adjustments	
GRAND TOTAL PAID	

Unit # ______ Fund #______ Total_________
Unit # ______ Fund #______ Total_________
Unit # ______ Fund #______ Total_________

ATCMHMR Office Use Only

Pg. 1 Total ________ _______________
Pg 2 Total ________ _______________
Pg. 3 Total ________ _______________
Pg. 4 Total ________ _______________
Pg. 5 Total ________ _______________
Pg. 6 Total ________ _______________
Pg. 7 Total ________ _______________
Pg. 8 Total ________ _______________
Pg. 9 Total ________ _______________

Authorized Provider Signature:___________________________________
(Consumer/Parent/Guardian, Individual Provider, **or** Director of Provider Organization)

Date:________________________

ATCMHMR Staff Signature:_____________________________________

Date:________________________

Revised 2/10/04

Page ______ of ______