

Provider Invoice First Page

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

<input type="checkbox"/> DD SERVICES	<input type="checkbox"/> ECI	<input type="checkbox"/> THE CHILDREN'S PARTNERSHIP	<input type="checkbox"/> ATCMHMR-CHILDREN'S PARTNERSHIP	<input type="checkbox"/> YAFAC
<input type="checkbox"/> Internal Contract Provider (DD)	<input type="checkbox"/> Internal Contract Provider (CFS)	<input type="checkbox"/> Internal Contract Provider (AMH)	<input type="checkbox"/> 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

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 Cost	Co-pay if applicable (Total per Consumer)	Line Total	FOR ATCMHMR OFFICE USE ONLY			
						# Units	Type*(circle one)				Invoice Received _____	Invoice Submitted to A/P _____	GL Acct. No. _____	Invoice No. _____
1							M D H S P			\$0.00	Voucher #	Unit #	Fund #	Adjust.
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: _____

Provider Invoice Middle Page

DD SERVICES ECI THE CHILDREN'S PARTNERSHIP ATCMHMR-CHILDREN'S PARTNERSHIP YAFAC
 Internal Contract Provider (DD) Internal Contract Provider (AMH) Internal Contract Provider (SASS) Internal Contract Provider (CFS)
 Internal Contract Provider: contracted to provider services at an ATCMHMR site or non MSO services

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 Cost	Co-pay if applicable (Total per Consumer)	Line Total	FOR ATCMHMR OFFICE USE ONLY				
						# Units	Type*(circle one)				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					
15							M D H S P			\$0.00					
16							M D H S P			\$0.00					
17							M D H S P			\$0.00					
18							M D H S P			\$0.00					
19							M D H S P			\$0.00					
20							M D H S P			\$0.00					
21							M D H S P			\$0.00					
22							M D H S P			\$0.00					
23							M D H S P			\$0.00					
24							M D H S P			\$0.00					
25							M D H S P			\$0.00					
26							M D H S P			\$0.00					
27							M D H S P			\$0.00					
28							M D H S P			\$0.00					
29							M D H S P			\$0.00					
30							M D H S P			\$0.00					
										Page Subtotal	\$0.00	Unit	Fund	Unit	Fund
										Less Co-pays (if applicable)	\$0.00				
										Provider Page Total	\$0.00				
										Adjustments	\$0.00				
										Approved Page Total	\$0.00				

Authorized Provider Initials: _____
 Organization/Provider Name (print) _____