Return Address
Office Code:
Office
Office Address:
City, State, Zip:

Month of Billing:

Utah State Department of Human Services
Provider Service Invoice

Number of Pages:

Worker Name:
Worker EIN:

Provider ID:

Provider Adress:
Name of Provider:
Address of Provider:
City, State, Zip:

Provider:
Enter the actual dates of service if different than those printed.
Enter the actual number of units that you provided.
ENTER AMOUNT and total each page.

Client/PID	Eligibility	Start Date	End Date	SVC	Unit of Service	Units	Rate	Subtotal	Initials

Page Total:
Grand Total:

I certify that the services listed on this statement were rendered on behalf of the above named persons; that this claim constitutes the full and complete charge for said services described above; that I will make no further claim for payment of these services; that these services have been provided without discrimination based upon age, race, color, creed, sex or national origin; that this statement is subject to Federal and State audit or review.

_____/_____/_____
Provider Signature **MO / DAY / YR**

By authorizing payment(s) I certify that each of these services were authorized at the appropriate rate listed on this billing and, to the best of my knowledge, were fully provided.

I also certify that I am the person responsible to authorize payment.

_____/_____/_____
Worker Signature **MO / DAY / YR**

I certify, to the best of my knowledge, the payment is proper.

_____/_____/_____
Approval Signature **MO / DAY / YR**

_____/_____/_____
Data Entry Signature **MO / DAY / YR**