

For your convenience, here are a few hints for using the RHCD Invoice template:

1. Save this file on a drive that you access on a regular basis (so you have a clean invoice template for next month's invoice).
2. Using the "Save As" feature, save this file again with a name of your choice that is appropriate for the invoice you are about to complete.
3. Enter information in the shaded areas only. The information required is found on the Support Schedule received from RHCD (with the exception of Service Provider Invoice Number - you assign this number).
4. If entering more than 20 line items, find additional invoice pages below page 1.
5. After all line items have been entered, verify the Total Invoice Amount located in the top section of the invoice.
6. To avoid printing blank invoice pages, specify the pages you have used in the Print Pages fields.
7. After printing, date, sign, print your name and phone number on the bottom of page 1.
8. Send the invoice to:

RHCD  
80 South Jefferson Road  
Whippany, NJ 07981

9. If you have any questions, please contact Karen Mogensen at 973-581-6756 (e-mail: [kmogens@neca.org](mailto:kmogens@neca.org)).

## RHCD SERVICE PROVIDER INVOICE

### FOR RHCD USE ONLY

Service Provider Name \_\_\_\_\_  
 SPIN \_\_\_\_\_  
 Service Provider Invoice Number \_\_\_\_\_  
 Invoice Date to RHCD (mm/dd/yy) \_\_\_\_\_  
 Total Invoice Amount \$0.00

Header  
Verification

\_\_\_\_ RHCD Processed Date \_\_\_\_\_  
 \_\_\_\_ Number of Records \_\_\_\_\_  
 \_\_\_\_ Number of Records Approved \_\_\_\_\_  
 \_\_\_\_ RHCD Approved Total Amount \_\_\_\_\_

#	Funding Year (yyyy)	HCP #	Funding Request #	Billing Account #	Multiple Months (Y or N)	Support Date (mmyyyy)	Support Amount to be Paid by USAC	Code
1								_____
2								_____
3								_____
4								_____
5								_____
6								_____
7								_____
8								_____
9								_____
10								_____
11								_____
12								_____
13								_____
14								_____
15								_____
16								_____
17								_____
18								_____
19								_____
20								_____

I certify that the information contained in this invoice is correct and that the health care providers and Billing Account Numbers listed above have been credited with the amount shown under "Support Amount to be Paid by USAC".

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name:

Telephone # :

## RHCD SERVICE PROVIDER INVOICE

Service Provider Name           0  
 SPIN                                   0  
 Service Provider Invoice Number   0  
 Invoice Date to RHCD (mm/dd/yy)   12/30/99  
 Total Invoice Amount                    \$0.00

	Funding Year (yyyy)	HCP #	Funding Request #	Billing Account #	Multiple Months (Y or N)	Support Date (mmyyyy)	Support Amount to be Paid by USAC	For RHCD Use Only- Code
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34								
35								
36								
37								
38								
39								
40								
41								
42								
43								
44								
45								

## RHCD SERVICE PROVIDER INVOICE

Service Provider Name            0 \_\_\_\_\_  
 SPIN                                        0 \_\_\_\_\_  
 Service Provider Invoice Number    0 \_\_\_\_\_  
 Invoice Date to RHCD (mm/dd/yy)   12/30/99 \_\_\_\_\_  
 Total Invoice Amount                                        \$0.00 \_\_\_\_\_

	Funding Year (yyyy)	HCP #	Funding Request #	Billing Account #	Multiple Months (Y or N)	Support Date (mmyyyy)	Support Amount to be Paid by USAC	For RHCD Use Only-Code
46								_____
47								_____
48								_____
49								_____
50								_____
51								_____
52								_____
53								_____
54								_____
55								_____
56								_____
57								_____
58								_____
59								_____
60								_____
61								_____
62								_____
63								_____
64								_____
65								_____
66								_____
67								_____
68								_____
69								_____
70								_____



## RHCD SERVICE PROVIDER INVOICE

Service Provider Name            0 \_\_\_\_\_  
 SPIN                                        0 \_\_\_\_\_  
 Service Provider Invoice Number   0 \_\_\_\_\_  
 Invoice Date to RHCD (mm/dd/yy)   12/30/99 \_\_\_\_\_  
 Total Invoice Amount    \$0.00 \_\_\_\_\_

	Funding Year (yyyy)	HCP #	Funding Request #	Billing Account #	Multiple Months (Y or N)	Support Date (mmyyyy)	Support Amount to be Paid by USAC	For RHCD Use Only- Code
96								_____
97								_____
98								_____
99								_____
100								_____
101								_____
102								_____
103								_____
104								_____
105								_____
106								_____
107								_____
108								_____
109								_____
110								_____
111								_____
112								_____
113								_____
114								_____
115								_____
116								_____
117								_____
118								_____
119								_____
120								_____