

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).

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
71								_____
72								_____
73								_____
74								_____
75								_____
76								_____
77								_____
78								_____
79								_____
80								_____
81								_____
82								_____
83								_____
84								_____
85								_____
86								_____
87								_____
88								_____
89								_____
90								_____
91								_____
92								_____
93								_____
94								_____
95								_____

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								_____