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 Prodiver 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

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

FOR RHCD USE ONLY

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: __________

Updated 3-8-04

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
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							

For RHCD Use Only- Code

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
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							

For RHCD Use Only- Code