TELECOMMUNICATIONS PROGRAM 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: __________

Print Name: ______________________ Telephone # : __________

OMB 3060-0804

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
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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								
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86								
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91								
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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								____
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120								____