

# TELECOMMUNICATIONS PROGRAM 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								_____
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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
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
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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								—
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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								_____
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