TELECOMMUNICATIONS PROGRAM INVOICE

FOR RHCD USE ONLY

Service Provider Name		Header Verification	
SPIN		____	RHCD Processed Date
Service Provider Invoice Number		____	Number of Records
Invoice Date to RHCD (mm/dd/yy)		____	Number of Records Approved
Total Invoice Amount	$0.00	____	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	For RHCD Use Only- Code
21								
22								
23								
24								
25								
26								
27								
28								
29								
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31								
32								
33								
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36								
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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								
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66								
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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								
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86								
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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								
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