DEPARTMENT OF HEALTH AND MENTAL HYGIENE
DEVELOPMENTAL DISABILITIES ADMINISTRATION
CSLA PAYMENT SYSTEM INVOICE

C.O.M.A.R. 21.01.03.01.A

EXEMPT from Procurement

Invoice Period: **From___/____/___ To____/____/____** **FY_____Quarter_____**

FEDERAL I.D. NUMBER Contract/Award Number:

_____PS PROVIDER NAME

STREET ADDRESS

CITY, STATE, ZIP

CONTACT PERSON_____TELEPHONE NUMBER_____

Please Print

****

NUMBER OF CONSUMERS _____

Quarterly Amount Due (from rate tables) $_____

ADJUSTMENT TO PRIOR PAYMENT

AMOUNT DUE STATE $_____

AMOUNT DUE PROVIDER $_____

ONE TIME ONLY (OTO) $_____

+ / - RECONCILIATION $_____

NET AMOUNT DUE PROVIDER *$*_____

ATTESTATION

I certify by my signature that this request for payment invoice is for services provided and does not represent any claims previously billed or received.

_____

NAME (*PLEASE PRINT)* *TITLE*

_____

SIGNATURE (BLUE INK) *DATE*

****

*

FOR DHMH USE ONLY

DDA APPROVED FOR PAYMENT_____

Signature ***Date***

DPCA Payment Amount $_____ **PCA: *P214G***

_____

Signature ***Date***

DHMH4513