AGENCY NAME
AGENCY ADDRESS
AGENCY CITY & STATE
AGENCY PHONE
BILLING REPRESENTATIVE
AGENCY CONTACT'S EMAIL ADDRESS

Date (Month/Year)	Service Provided	Total Amount

Invoice Total -

Provider Officials

Prepared By:

_____ _____
Name Signature

_____
Title Date _____

EASTERSEALS OF NORTHEAST CENTRAL FLORIDA

The invoice has been reviewed, adjusted, if necessary, and entered in the database system.

Date entered _____ Check #_____

Staff Signature _____ Date Payment Mailed_____

Program Director
Approval Signature _____