

INVOICE SUMMARY - PAYMENT REQUEST

DMH CONTRACT
Exhibit B

PROVIDER NAME _____		CLAIM PERIOD _____		
PROVIDER # _____				
	TOTAL UNIT OF SERVICE	GROSS COST	SHARE OF COST	NET BILLING
AMOUNT CLAIMED		\$0.00		\$0.00
ADJUSTMENTS:				
Retro Share of Cost				\$0.00
TOTAL CLAIMED	0	\$0.00	\$0.00	\$0.00

I hereby certify that the clients listed above were cared for in the above named facility for the period stated.

Signature: _____

Administrator/Operator Facility Date

I hereby certify that to the best of my knowledge, the above statement is correct in accordance with the law.

Name and Title: _____

Administrator Approval Signature Date

FOR IMD ADMINISTRATION USE ONLY:

		DATE _____		
IMD ADMINISTRATION APPROVAL SIGNATURE _____				
	TOTAL UNIT OF SERVICE	GROSS COST	SHARE OF COST	NET BILLING
APPROVED CLAIM AMOUNT	0	\$0.00	\$0.00	\$0.00
COMMENTS: _____				