MISSOURI DEPARTMENT OF HEALTH
DIVISION OF INJURY PREVENTION, HEAD INJURY REHABILITATION
AND LOCAL HEALTH SERVICES

| AND LOCAL HEALTH SERVICES   |  |  | DATE   | INVOICE NUMBER   |  | PAGE NUMBER  |
|---|--|--|--|--|--|--|
| HEAD INJURY SERVICES INVOI  | INVOICE  |  |  |  |  |  |
| SUBMIT TO: MISSOURI DEPARTMENT OF HEALTH  | VENDOR   |  | a) Allektronen over the second of the second over the second o | VENDOR NUMBER  | No. of the contract of the con | FISCAL YEAR  |
| DIVISION OF INJURY PREVENTION,<br>HEAD INJURY REHABILITATION &<br>I OCAI HEATTH SERVICES  | ADDRESS  |  | GITY   | AGREEMENT NUMBER   | ВЕЯ  | AGENCY CODE 597  |
| P.O. BOX 570<br>JEFFERSON CITY, MO 65102-0570   | STATE  | ZIP CODE   | PHONE NUMBER   | COST CENTER CODE   | CODE<br>71836  | 08JECT CODE <b>2445</b>  |
| SECTION A - TOTAL SERVICES BILLED FOR PERIOD OF INVOICE   | D FOR PERIOD OF INV  | OICE   |  |  |  | The state of the s |
| SERVICE DESCRIPTION   | SERVICE CODE   | NUMBER OF<br>CLIENTS   | TOTAL NUMBER<br>OF UNITS   | MONTH  | TOT  | TOTAL(\$) SERVICE<br>AMOUNT BILLED   |
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|   |  | 5  | GRAND TOTAL (\$) AMOUNT BILLED   | MOUNT BILLED   | €9   | The state of the s |
| I certify that the services have been rendered in accordance with the Provider Agreement and that I have not received prior payments for the services. If payment is received from another source, the Department of Health will be either reimbursed up to the amount involved or the amount received will be deducted from the amount billed to the state. I also certify that the services billed to the Department of Health are provided to clients who have suffered a head injury as defined in the Provider Manual and that the clients are Missouri residents. | dered in accordance volepartment of Health vortify that the services its are Missouri resident   | with the Provider A will be either reimboilled to the Depart is. | greement and that I unred up to the amoment of Health are p  | have not received pri<br>bunt involved or the<br>rovided to clients wh   | or payments f<br>amount receiv<br>o have suffere   | accordance with the Provider Agreement and that I have not received prior payments for the services. If payment it of Health will be either reimbursed up to the amount involved or the amount received will be deducted from the services billed to the Department of Health are provided to clients who have suffered a head injury as defined isouri residents.   |
| AUTHORIZED SIGNATURE  | DATE   |  | APPROVAL SIGNATURE   |  |  | DATE   |
| MO 580-1707 (5-93)  |  |  |  |  |  |  |

# INSTRUCTIONS FOR COMPLETION

NOTE: The original and three copies of Section A and Section B must be complete and legible. Submit to Missouri Department of Health, Division of Injury Prevention, Head Injury Rehabilitation & Local Health Services, P.O. Box 570, Jefferson City, Missouri, 65102. Phone: (314) 751-6170.

DATE: Date form is completed.

INVOICE NUMBER: Assign an invoice number.

PAGE NUMBER: Sequentially numbered.

VENDOR: Name, address and phone number of vendor.

VENDOR NUMBER: 7 digit number assigned by OA to identify as specific vendor.

FISCAL YEAR: (already completed).

AGREEMENT NUMBER: Complete your agreement number.

AGENCY CODE: (already completed).
COST CENTER CODE: (already completed).
OBJECT CODE: (already completed).

#### **SECTON A**

SERVICE DESCRIPTION: Services being billed for (i.e., assessment, functional living rehabilitation, day program, recreation, etc.)

SERVICE CODE: Enter service code listed below.

NUMBER OF CLIENTS: Number of clients who received the service.

TOTAL NUMBER OF UNITS: Total number of units billed for this service.

MONTH: 2 digit month the services invoice applies.

TOTAL (\$) SERVICE AMOUNT BILLED: Total amount due by service.

GRAND TOTAL (\$) AMOUNT BILLED: Total amount due.

AUTHORIZED SIGNATURE: Authorized signature of person authorized to sign invoice and date signed.

APPROVAL SIGNATURE: Head Injury Program approval signature.

## **SECTION B**

#### CLIENT NAME:

MONTH: 2 digit month the services invoice applies.

SERVICE CODE: Enter service code listed below.

TOTAL UNITS AUTHORIZED: Total number of units that have been approved.

TOTAL UNITS USED: Total number of approved units that have been used.

UNITS USED THIS MONTH: Units billed for client this month.

COST PER UNIT

TOTAL (\$) BILLED THIS MONTH: Unit times (x) unit cost.

PAGE TOTAL: Total amount of services billed to the state on this page only.

AUTHORIZED SIGNATURE: Of person authorized to sign invoice and date signed.

APPROVAL SIGNATURE: Head Injury Program approval signature.

## SERVICE CODE

- 001 Functional Living Rehabilitation
- 002 Day Activity Program
- 003 In-Home Support
- 004 Pre-Vocational-Pre-Employment Training
- 005 Recreation Services
- 006 Transportation-Program
- 007 Supported Employment-Long Term Extended Group Job Supervision
- 008 Supported Employment-Long Term Follow-Up
- 009 Community Support Services
- 010 Special Instruction
- 011 Physical Therapy Evaluation/Therapy
- 012 Occupational Therapy Evaluation/Therapy
- 013 Speech/Language Therapy Evaluation/Therapy
- 014 Psychologist/Neuropsychologist Evaluation
- 015 Counseling Psychologist
- 016 Counseling Social Worker
- 017 Counseling Licensed Counselor

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| SECTION B - ITEMIZATION OF BILLING   |   | (Should correspond to Section A)   | d to Section A)  |  |   | PAGE   | _ OF   |
|--|---|--|--|--|---|--|--|
| CLIENT NAME  | MONTH   | SERVICE<br>CODE  | TOTAL UNITS<br>AUTHORIZED                                  | TOTAL UNITS<br>USED  | UNITS USED<br>THIS MONTH  | COST PER UNIT  | TOTAL (\$) BILLED<br>THIS MONTH  |
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|  |   |  |  |  |   | PAGE TOTAL   | 4  |
| I certify that the services have been rendered in accordance with the Provider Agreement and that I have not received prior payment for the services. If payment is received from another source, the Department of Health will be either reimbursed up to the amount involved or the amount received will be deducted from the amount billed to the state. I also certify that the services billed to the Department of Health are provided to clients who have suffered a head injury as defined in the Provider Manual and that the clients are Missouri residents. | been rendered in<br>the Department<br>also certify that<br>he clients are Mis | accordance with of Health will the services bille souri residents.   | n the Provider Ag<br>be either reimbu<br>ed to the Departn | greement and tha<br>ursed up to the a<br>nent of Health are  | t I have not received<br>imount involved or the<br>provided to clients  | prior payment for the<br>he amount received w<br>who have suffered a h   | services. If payment<br>rill be deducted from<br>lead injury as defined  |
| AUTHORIZED SIGNATURE   |   | DATE   |  | APPROVAL SIGNATURE   | ME  | DATE   |  |
| MO 580-1707 (5-03)   |   |  |  |  |   |  |  |

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