Blanket Independent Provider Invoice

Provider Name: _____

Provider Address: _____

Provider SSN# (required) _____ - _____ - _____

DD Eligible Individual: _____

Date	Type of Service	Total Hours Or Trips	Rate	Total Paid
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
Total Due				$ 0.00

Send to Attn: Accounts Payable, 20 E 1st St, New Bremen, OH 45869
or Email billing@auglaizedd.org

** Payment cannot be made without the SSN#.
Invoices may be submitted on the 1st & 15th of
the month.**