Iowa Department Of Human Services

PURCHASE OF SERVICES PROVIDER INVOICE

DHS use only

Invoice No. _____

Agreement No. _____

Provider Name _____
(Please print or type)

Billing Period _____ State/Local _____

Provider Addr _____

County No. and Name _____
(Please print or type)

City/State _____ Zip _____

	Case Number	Client's Name Last	First	M.	Service Date Beginning	Ending	Service Code	Unit Cost	No. of Units	Total Cost	Fees	Credits	Net Cost
01													
02													
03													
04													
05													
06													
07													
08													
09													
10													
11													
12													
							TOTALS						

I certify that the items for which payment is claimed were provided and are unpaid.

Claimant_____ Date_____

Approval_____ Date_____