Invoice

Therapist Name _____ **Discipline** _____ **Invoice Number** _____

Facilty Name/Service Site _____ **Service Month** _____

Date of Service	Patient Name	Patient ID	Type of Visit (OIG/IE/PN/D/C	Documentation Type (Manual/Electronic) and Enclosure HEP/NOMNC/OASIS
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/ /				
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/ /				
/ /				
	Total Number of Visits			

_____ _____ _____ _____

Facility Approver Name **Facility Approver Title** **Facility Approver Signature** **Facility Approver Date Signed**

_____

Clinician Signature

I certify that homecare invoices are either faxed or emailed from a business email and the email is encrypted.