# Invoice

**Provider:**

Provider Name

Address

City, State, Zip

Phone

**Invoice Number:**

**Invoice Date:**

**Provider Staff Name:**

**Bill To:**

VRS Staff Name, Vocational Rehabilitation Services, Address, City, State, Zip, Email Address

**Participant Name: Authorization Number:**

| **Date(s) of Service** | **Service Delivery** | **Service**  | **Hours** | **Hourly Rate** | **Total Amount** |
| --- | --- | --- | --- | --- | --- |
|  | [ ]  Individual/1:1[ ]  Group |  |  |  |  |
|  | [ ]  Individual/1:1[ ]  Group |  |  |  |  |
|  | [ ]  Individual/1:1[ ]  Group |  |  |  |  |
|  | [ ]  Individual/1:1[ ]  Group |  |  |  |  |
|  | [ ]  Individual/1:1[ ]  Group |  |  |  |  |

Total Invoiced: $