Connecticut Autism Pilot Program
Vendor Billing Invoice Form

Consumer Name: _____
(Last, First)

F.I.

Billing Month: _____

Vendor Name/Address:

Phone #

Vendor EIN #: _____

Date	Service/Commodity Type	Procedure Code	Unit	# Units	Unit Rate	Total
					Subtotal	
					Grand Total	

Certification : I certify that the services listed above are true , accurate and complete. I further certify that the services are proper charges against the State of Connecticut and that payment has not been received from other sources. I certify that the services were provided in accordance with applicable Medicaid requirements and with other rules and guidelines as defined by the Connecticut Department of Mental Retardation.

_____ _____
Signature Date

_____
Print Name

Key: **Service Type & Procedure Codes =**

Units =

Issued on 2/25/05
Revised on 8/25/05

Consumer Name: _____
(Last, First)

DMR # _____

Date	Service/Commodity Type	Procedure Code	Unit	# Units	Unit Rate	Total
					Total Page 2	