Department of Developmental Services
Vendor Billing Invoice Form

Consumer Name: ______________________
(Last, First)

DDS# __________

F.I.

Billing Month: ______________________

Vendor Name/Address:

Phone #:

Invoice # :

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 tru, 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 Developmental Services.

Signature   Date

Print Name

Key:

Consumer Name: _____ Page 2 of 2
(Last, First)

DDS # _____

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