Sample Rural Health Care Pilot Program Invoice Template

Project Name	
Service Provider Name	
SPIN	
Service Provider Invoice Number	
Invoice Date to RHCD (mm/dd/yy)	
Billing Account Number (BAN)	
Total Invoice Amount	**$0.00**

HCP Number	
FRN	
Funding Year	2007

FOR RHCD USE ONLY
Header Verification
____ RHCD Processed Date
____ Number of Records
____ Number of Records Approved
____ RHCD Approved Total Amount

	NCW ID	Category	Sub Category	Item	Speed	Total # of Items Approved	# of Items requested this invoice	Approved Cost per Item	Actual Cost Per Item	Total Cost	Total Approved Cost	RHC Funding % Requested (max 85%)	Participant Contribution Amount	Support Amount to be paid by USAC	Code
1										$ -	$ -	$ -	$ -	$ -	
2										$ -	$ -	$ -	$ -	$ -	
3										$ -	$ -	$ -	$ -	$ -	
4										$ -	$ -	$ -	$ -	$ -	
5										$ -	$ -	$ -	$ -	$ -	
6										$ -	$ -	$ -	$ -	$ -	
7										$ -	$ -	$ -	$ -	$ -	
8										$ -	$ -	$ -	$ -	$ -	
9										$ -	$ -	$ -	$ -	$ -	
10										$ -	$ -	$ -	$ -	$ -	
11										$ -	$ -	$ -	$ -	$ -	
12										$ -	$ -	$ -	$ -	$ -	
13										$ -	$ -	$ -	$ -	$ -	
14										$ -	$ -	$ -	$ -	$ -	
15										$ -	$ -	$ -	$ -	$ -	
16										$ -	$ -	$ -	$ -	$ -	
17										$ -	$ -	$ -	$ -	$ -	
18											$ -	$ -	$ -	$ -	
19										$ -	$ -	$ -	$ -	$ -	
20										$ -	$ -	$ -	$ -	$ -	
21										$ -	$ -	$ -	$ -	$ -	
22										$ -	$ -	$ -	$ -	$ -	
23										$ -	$ -	$ -	$ -	$ -	
24										$ -	$ -	$ -	$ -	$ -	
25										$ -	$ -	$ -	$ -	$ -	

Service Provider Certification

1. I certify that I am an authorized representative of the above-named service provider, that I have examined the information provided in the Rural Health Care Pilot Program Invoice, and to the best of my knowledge, information and belief, all costs contained in this invoice are true and correct and represent actual incurred costs for network build-out or related services received by each participating health care provider.

Signature: _____ **Date:** _____ **Phone #:** _____

Print Name: _____ **Email:** _____

Project Coordinator Certification

1. I certify that I have examined the information provided in the Rural Health Care Pilot Program Invoice, and to the best of my knowledge, information and belief, the participating health care providers have received the network build-out or related services itemized on this invoice. I certify under penalty of perjury that the 15 percent minimum funding contribution for each item on this invoice required by the Rural Health Care Pilot Program rules was funded by eligible sources as defined in the rules and has been provided to the service provider.

Signature: _____ **Date:** _____ **Phone #:** _____

PC Name: #N/A **Email:** _____