Billing Invoice

Therapist name:______________________________________

Address:____

Phone:____

SSN:____

FEIN #:____

DI___Para___OT___PT___ST___

Auth #	County	Child's Name	Service Date	Total Services	Fee

Total:

Claimant's Certification and Declaration

I do solemnly declare and certify that all hours specified above have been previously approved by the IFSP and are hereby in compliance with the Contractual Agreement between Progressive steps and the New Jersey Department of health and Senior services. Furthermore I fully Accept and Acknowledge that any hours which may exceed the time allotted by said contractual agreement may not be presented for payment at the discretion of Progressive Steps.

Therapist signature X   Date:

^Consults Sign and Return for Payment^