

SUMMARY PAGE FOR REIMBURSEMENT INVOICES FOR PATIENT CARE SERVICES

(Use this summary page only when the patient care services invoice exceeds one page)

AGENCY:

BILLING PERIOD:

PAGE NO.	TRANSPORTATION TOTAL	SERVICE REIMBURSEMENT TOTAL	TOTALS
1			\$0.00
2			\$0.00
3			\$0.00
4			\$0.00
5			\$0.00
6			\$0.00
GRAND TOTAL	\$0.00	\$0.00	\$0.00

AIDSNET USE ONLY

Date Received: _____

Reviewed: _____

INVOICES/REPORTS ARE DUE IN THE AIDSNET OFFICE BY THE 5TH OF THE MONTH FOLLOWING THE LAST DAY OF THE MONTH IN WHICH SERVICES ARE RENDERED

Prepared By _____ Phone Number _____

CERTIFICATION STATEMENT

I certify that I am the Executive Director/Administrator of said organization, and that this Reimbursement Invoice is true and correct to the best of my knowledge and belief; and that no direct payments have been made to any clients as per subgrant/agreement with AIDSNET. Also, I understand that submission of this invoice is not a guarantee of payment by AIDSNET.

Executive Director/Administrator

Date: _____

AIDSNET APPROVAL

Ann Stuart Thacker, Executive Director

Date: _____