

Name
 Address
 City, State, Zip
 Phone #, E-mail address

CLINICAL SERVICES INVOICE

Bill To:
Central Valley Regional Center 4615 N. Marty Ave. Fresno, CA 93722-4186

Remit payment to address: _____

Invoice #	
Invoice Date:	
Operations Vendor #	

Date(s) of Service	# of Service Units/Hours	Service description: 1) Assessment 2) Baby Clinic 3) Chart review 4) Consultation 5) Evaluation 6) Genetic 7) Staffing 8) Telemedicine 9) Other services	Client/Person(s) meet with	Rate	Total
					\$ -
					\$ -
					\$ -
					\$ -
					\$ -
					\$ -
					\$ -
					\$ -
					\$ -
					\$ -
					\$ -
					\$ -
					\$ -
					\$ -
					\$ -

Contractor Signature: _____

Program Manager Signature: _____

Approved by: _____

Total	\$ -
Travel from Reverse side	\$ -
Other	
Amount Due	\$ -

