Emilia's kids
84-03 57th Avenue
Elmhurst, NY 11373
718.899.9060

Monthly Invoice

Therapist:	Service Type:	Month of Service

Please Circle dates that you saw the child — Rate x #session = Total

Child	EI#	Auth Date	Place	Mandate
			☐ Home ☐ Center	2 x 30

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 26 27 28 29 30 31 — 30 / 60 ______ x _______ =_______

Child	EI#	Start Date	Place	Mandate:
			☐ Home ☐ Center	

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 26 27 28 29 30 31 — 30 / 60 ______ x _______ = _______

Child	EI#	Start Date	Place	Mandate:
			☐ Home ☐ Center	

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 26 27 28 29 30 31 — 30 / 60 ______ x _______ = _______

Child	EI#	Start Date	Place	Mandate:
			☐ Home ☐ Center	

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 26 27 28 29 30 31 — 30 / 60 ______ x _______ = _______

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I verify that there services were provided as per frequency and duration and if not, I submitted a <u>NOTICE OF 3 CONSECUTIVE MISSED HOME-BASED SESSIONS</u> via fax, email or with this invoice. Failing to follow DOH requirements will delay billing and payment.

Total Invoice: ________________
Deduction: ______________

Therapist Signature: ______________________________
Revised 4.13.2016