State of Alaska - Department of Health & Social Services (DHSS)
Division of Senior & Disabilities Services (SDS)
Telehealth Assessment Provider Invoice

SAMPLE INVOICE for Electronic Fillable Version
email: dsdstelehealth@alaska.gov

Provider _____ **SDS Provider Agreement Number** _____

Mailing Address _____ **IRIS Vendor/Customer Number** _____

Phone Number _____ **Invoice Month and Year (INV)** _____

Location	Date of Assessment	SDS Number	Fixed Rate $71.25	SDS Adjustments if necessary

Total Reimbursable Amount $ -

Certification:
I certify that to the best of my knowledge and belief, this claim is true and correct in all respects, that records are available to support this claim and that it is in accordance with the terms and conditions of the existing agreement.

Print Name & Title of Preparer/Authorizer _____

Phone Number _____

Email Address _____

Signature _____

Date _____

For SDS use ONLY:

SDS Program Reviewer Authorization for Payment _____

Date Received _____

SDS Admin Authorization for Payment _____

IRIS Vendor/Customer Number: _____

Provider: _____

SDS Provider Agreement Number: _____

Amount	$ -
Fund	1004
Dept	06
Unit	8000
Sub Unit	8016
Appr Unit	062316601
Object	6063
Activity	8067
Program	*993