Vendor Invoice for Services Rendered to Special Needs Clients Placed by the Multiagency Special Needs Shelter Discharge Planning Team

Payments will be processed in accordance with section 215.422, F.S.

Disaster / Emergency Event: _____

Mission #: _____ County: _____

Vendor Name & AHCA Facility License Number: _____

Vendor Address: _____

Vendor FEID#: _____

Vendor Phone Numbers: Office: _____ Fax: _____

Cell: _____ Other: _____

Vendor Contact Name: _____

Patient Name and Date of Birth: _____

Date of Admission: _____ Date of Discharge: _____

Date	Description of Goods/Services Provided	Invoice Amount (attach invoice)
		Total:

Case Manager: _____ Contact Number: _____

☐ Enclosed proof of a written request from a representative of an agency serving on the Multiagency Special Needs Shelter Discharge Planning Team that the individual for whom the facility is seeking reimbursement for services rendered was referred from a Special Needs Shelter.

Agency Representative Name _____ Contact Number_____

☐ Vendor verifies that the above described services are not covered under any other pay source consistent with section 381.0303(4)(b), F.S.

Vendor Signature: _____ Date: _____

Return completed form to: Department of Health, Bureau of Finance and Accounting, 4052 Bald Cypress Way, Bin #B01, Tallahassee, FL 32399-1729

ESF 8 Use Only

FEMA Category: _____ Object Code: _____

72 HRS Status: _____ Audited by: _____

DH 1990 (Rev. 01/17) Rule 64-3.015, F.A.C.