SSIP FL-EPIC Provider Reimbursement Invoice

Provider Name:

Agency Name:

Address:

Month/Year

Hourly rate: $ 50.00

Phone:

Email:

Training:	Date:	Start time	End time	Duration	Fee
FLEPIC-ESPD					$ 0.00
FLEPIC-ESPD					$ 0.00
FLEPIC-ESPD					$ 0.00
FLEPIC-ESPD					$ 0.00
FLEPIC RESEARCH STUDY					$ 0.00
FLEPIC RESEARCH STUDY					$ 0.00
MENTORSHIP					$ 0.00
MENTORSHIP					$ 0.00
other					$ 0.00
				SUBTOTAL	$ 0.00

Video Review:

Date:	Child ID/Session#	Start Time:	End Time:	Duration	Fee
					$ 0.00
					$ 0.00
				SUBTOTAL	$ 0.00

Coaching Session:

Date:	Child ID/Session#	Session Type	Start Time:	End Time:	Duration	Fee
		Select a Coaching S				$ 0.00
		Select a Coaching S				$ 0.00
					SUBTOTAL	$ 0.00

Total Amount Invoiced $ 0.00

Provider Signature **Date**

Mentor Signature **Date**

LIC Signature: **Date**

Approval Signature **Date**

HPC Expense Coding ES26-PDDC-53561

HPC Expense Coding-GC GCE26-PDCC-53561