Oklahoma HealthCare Authority

INVOICE

Company: ______________________
Address: ______________________
____
Phone: ______________________

Date: ____________________
INVOICE #: _____________
Service: Quality of Life______

TO: Oklahoma Health Care Authority
Please send all invoices **{secured}** to: Purchasing@okhca.org
For all other inquires, please call Living Choice at:
Tel. 1-888-287-2443

RID	Last NAME	First NAME	Date QoL Completed	Baseline Second Follow-Up Third Follow-Up	Service Description	Rate $100.00	Participant Total
						Total	

Provider Agency Approval: ______________________________ **Date:** ____________

Total Amount Billed on this Invoice: $____________________ **Director Approval:** ______________________________________