Invoice Number: DDSD-FY17-

DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION

DDSD MONTHLY INVOICE

Provider Name: _____

Provider Agreement / Contract Number: _____ **Month of Service:** _____

Respite					
Service Unit	Service	# of Individuals Served	# of Units Provided	Unit Rate	Dollar Amount
700031	Respite (0 - Adult)	0	0	$ 13.25	$ -
				Respite Total	$ -

Adult Service					
Service Unit	Service	# of Individuals Served	# of Units Provided	Unit Rate	Dollar Amount
700016	Day Hab. / Supported Employment	0	0	$ 739.00	$ -
700017	Residential	0	0	$ 1,530.00	$ -
700018	Outcome Based	0	0	$ 1.00	$ -
				Adult Total	$ -

Special Projects					
Service Unit	Service	# of Individuals Served	# of Units Provided	Unit Rate	Dollar Amount
700019	Behavioral Services	0	0	$ 1.00	$ -
700020	Adult Therapy Sevices	0	0	$ 1.00	$ -
				Adult Total	$ -

Supplemental Section (for revisions / supplements to billing from previous months)					
Month:					
Service Unit	Service	# of Individuals	# of Units Provided	Unit Rate	Dollar Amount
		0	0		$ -
		0	0		$ -
				TOTAL	$ -

Invoice Total: **$ -**

Provider Billing Contact Name: _____ **Tel #:** _____

Remit to address:

Date Invoice Submitted: _____

For questions regarding reimbursement, please call at 505-476-8829 or 476-8971
Email Invoice directly to: DDSD.Invoices@state.nm.us