Cost Reimbursement Invoice Form

COUNTY OF MONTEREY, Behavioral Health Bureau

Contractor :	Crestwood Behavioral Health, Inc.
Address Line 1	520 Capitol Mall, Suite 800, Sacramento, CA 95814
Address Line 2	Crestwood Center, 1425 Fruitdale Ave, San Jose, CA 95128
Tel. No.:	**916-471-2242**
Fax No.:	**916-471-2212**
Contract Term:	November 1, 2012 thru June 30, 2013

Invoice Number :

County PO No.:

Invoice Period :

Final Invoice : (Check if Yes)

FUNDED PROGRAM:

AVATAR Program,Mode and Service Function Code

Financial Eligibility (Admision Criteria)

Unduplicated Number of Clients Served:

Identify Program

Service Description	Mode of Service	SFC	Procedure Code	Units of Service (UOS) Delivered to Date	Total UOS Delivered as of Last Period	UOS Delivered this Period	Negotiated Rate per Unit	Amount of UOS at Negotiated Rate	Dollar Amount Requested this Period	Total Dollar Amount Requested last Period	Dollar Amount Requested Year-to-Date
											$ -
										$ -	$ -
											$ -
											$ -
											$ -
											$ -
											$ -
											$ -
											$ -
TOTALS								$ -	$ -	$ -	$ -

I certify that the information provided above is, to the best of my knowledge, complete and accurate; the amount requested for reimbursement is in accordance with the contract approved for services provided under the provision of that contract. Full justification and backup records for those claims are maintained in our office at the address indicated.

Signature: _____ Date: _____

Title: _____ Telephone: _____

Send to: MCHDBHFinance@co.monterey.ca.us
Behavioral Health Claims Section

Behavioral Health Authorization for Payment

Authorized Signatory _____ Date _____