Return Address

Utah State Department of Human Services
Provider Service Invoice

DCFS (SAFE)

Date Range to

Provider ID:

Provider:
Enter the actual dates of service.
Enter the actual number of units that you provided.
ENTER AMOUNT and total each page.

Provider Address

Client / PID	Case Worker/ Review Worker	Start Date	End Date	SVC	Unit of Service	Max Units	Rate	Subtotal	Initials

Page Total:
Grand Total:

I certify that the services listed on this statement were rendered on behalf of the above named persons; that this claim constitutes the full and complete charge for said services described above; that I will make no further claim for payment of these services; that these services have been provided without discrimination based upon age, race, color, creed, sex or national origin; that this statement is subject to Federal and State audit or review.

/ /
Provider Signature MO / DAY / YR

By authorizing payment(s) I certify that each of these services were authorized at the appropriate rate listed on this billing and, to the best of my knowledge, were fully provided.

I also certify that I am the person responsible to authorize payment.

/ /
Case Worker (Approver 1) Signature MO / DAY / YR

I certify, to the best of my knowledge, the payment is proper.

/ /
Data Entry or Supervisor (Approver 2) Signature MO / DAY / YR