

IEP SERVICE INVOICE

Provider Name: _____

License/NPI: _____

Invoice #: _____

Date: _____

BILL TO:

School District / Agency Name

STUDENT INFORMATION:

Name: _____

ID #: _____

DOB: _____

Date of Service	IEP Goal Ref #	Service Description (Speech, OT, PT, etc.)	Units/Hours	Rate	Total

Subtotal: \$ _____

Tax/Fees: \$ _____

Amount Due: \$ _____

Notes/Observations: _____

Provider Signature: _____ **Date:** _____