

INVOICE

Consultant: [Name/Agency]
[Address Line 1]
[City, State, Zip]
[Email/Phone]

Invoice #: [0000]
Date: [Date]
Due Date: [Date]

BILL TO

[Facility/Provider Name]
[Contact Person]
[Billing Address]
[NPI Number if applicable]

PROJECT/ENGAGEMENT

[e.g., Joint Commission Prep]
[Audit Period: MM/DD/YY - MM/DD/YY]

Compliance Service Description	Quantity/Hours	Rate	Amount
[e.g., Clinical Documentation Audit]	[0.00]	[\$[0.00]]	[\$[0.00]]
[e.g., HIPAA Risk Assessment]	[0.00]	[\$[0.00]]	[\$[0.00]]
[e.g., Policy & Procedure Development]	[0.00]	[\$[0.00]]	[\$[0.00]]

Subtotal: \$[0.00]
Expenses/Travel: \$[0.00]

Total Due: \$[0.00]

Payment Instructions: [e.g., Check payable to Name, ACH, or Wire info]

Notes: Behavioral health compliance services rendered are confidential under applicable state and federal laws. Please contact [Name] with any billing discrepancies.