

FRAUD PREVENTION SERVICES INVOICE

Invoice #: [0000]
Date: [MM/DD/YYYY]

Provider / Vendor:

[Entity Name]
[Tax ID / NPI Number]
[Address]
[Contact Email]

Client / Healthcare Facility:

[Facility Name]
[Compliance Department]
[Address]

Service Description (CPT/HCPCS if applicable)	Hours/Units	Rate	Total
Compliance Audit & Claims Review	[0.00]	[\$[0.00]]	[\$[0.00]]
FWA (Fraud, Waste, & Abuse) Training	[0.00]	[\$[0.00]]	[\$[0.00]]
Risk Assessment & Internal Monitoring	[0.00]	[\$[0.00]]	[\$[0.00]]

Amount Due: \$[0.00]

Compliance Statement: This invoice reflects services rendered in accordance with the False Claims Act and Anti-Kickback Statute regulations. All services documented are necessary for the prevention and detection of healthcare fraud, waste, and abuse. No payments herein are intended for the referral of Federal health care program business.