[Facility Name]

[Street Address]
[City, State, Zip]
[Phone Number]
[Tax ID/NPI]

INVOICE

Invoice #: _____
Date: _____
Due Date: _____

BILL TO

[Client Name/Department]
[Organization]
[Address]
[Email Address]

COMPLIANCE PERIOD

Start Date: _____
End Date: _____
Regulatory Body: [CMS/State Dept of Health]

Service Description (Tag/Requirement)	Quantity/Hours	Rate	Total
Annual Certification Survey Prep			
Plan of Correction (POC) Development			
Staff Training: HIPAA/Safety Compliance			

Service Description (Tag/Requirement)	Quantity/Hours	Rate	Total
Mock Survey Audit & Reporting			
Life Safety Code Review			

Subtotal: $0.00
Regulatory Fees/Tax: $0.00

Amount Due: $0.00

NOTES & PAYMENT INSTRUCTIONS

Please make all checks payable to **[Facility/Company Name]**. Payment is due within [Number] days. Late payments may be subject to a [Percentage]% monthly finance charge.

Thank you for your commitment to resident care and regulatory excellence.