PAYMENT RECEIPT

All claims MUST be submitted within 30 days of care taking place **Today's Date**

PROVIDER INFORMATION

Provider/Business Name

Street Address

City **State** **Zip Code**

Phone number

SERVICE DETAIL

Name of Benefit Holder

Care Recipient(s) full name(s)/Age(s)

Service Description

Service Rate ◉ Per Hour ○ Per Day

DATES OF CARE	HOURS OF CARE (REQUIRED)		SERVICE RATE	TOTAL RATE
	Start Time	End Time		
			$	$
			$	$
			$	$
			$	$
			$	$

TOTAL $

I certify that the information above, including dates of care and payment received by the above benefit holder, is true.
I understand that I may be contacted by a representative to verify care.

Provider Signature **Date**