STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

DATE:			
PAGE NO.		of	

CIMOR SERVICE ENCOUNTER INVOICE

VENDOR NAME		SAM II VENDOR CODE	
VENDOR ADDRESS		CONTRACT NO.	
		SERVICE CATEGORY	**ADA Recovery Supports**
SUBMIT TO:	DEPARTMENT OF MENTAL HEALTH P.O. BOX 687 JEFFERSON CITY, MO 65102	ORG CODE	**5329**
		FISCAL YEAR	**2007**
		DIVISION	**ADA**
CONSUMER LAST NAME		**CONSUMER FIRST NAME**	
CONSUMER DMH ID NO.		**CONSUMER VOUCHER NO.**	

DATE (MM/DD/YY)	PROCEDURE CODE	UNIT PRICE	UNITS	SERVICE AMOUNT	D.M.H. CENTRAL OFFICE USE ONLY
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AUTHORIZED SIGNATURE

PAGE TOTAL $ -

I certify that the services have been rendered and that I have not received payment. If payment is received from some other source, the Department of Mental Health will be reimbursed up to the amount invoiced.

GRAND TOTAL $ -