## Vendor Invoice for Special Needs Health Care Practitioner

Payments will be processed in accordance with section 215.422, F.S.

Disaster / Emergency Event: _____

Mission #: _____

County: _____

Health Care Practitioner (HCP) Name and License #: _____

HCP Address: _____

HCP FEID#: _____

HCP Phone Numbers: Office: _____ Fax: _____

Cell: _____ Other: _____

HCP Contact Name: _____

Patient Name and Date of Birth: _____

Date of Admission: _____ Date of Discharge: _____

| Date | Description of Goods/Services Provided | Invoice Amount (attach invoice) |
|---|---|---|
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| | | |
| | | |
| | | Total: |

☐ Vendor verifies that the above described services are not covered under any other pay source consistent with section 381.0303(4)(b), F.S.

HCP Signature: _____ Date: _____

**Return completed form to: Department of Health, Bureau of Finance and Accounting, 4052 Bald Cypress Way, Bin #B01, Tallahassee, FL 32399-1729**

**ESF 8 Use Only**

FEMA Category: _____ Object Code: _____

72 HRS Status: _____ Audited by: _____