County of Los Angeles-Department of Mental Health-Provider Reimbursement Unit

Monthly Claim for Reimbursement

Fiscal Year 2004 - 2005

Funding Source Billed to: _____ **Correct Funding Source:** _____

Legal Entity Name: _____

Legal Entity Mailing Address: _____

Billing Month: _____ Contract Amendment Number: _____

						Revenue				Total
Provider #	Rptg. Unit	Mode / SFC	Rate	IS Units	Gross Claimable	SSI	Grants	Insurance	Patient Fees	Net Amount
					-					-
					-					-
					-					-
					-					-
					-					-
					-					-
					-					-
					-					-
					-					-
					-					-
					-					-
					-					-
				Totals	-	-	-	-	-	-	-

Comments: _____

I hereby certify that all information contained above is true and correct to the best of my knowledge.

* Please complete a "Monthly Claim for Reimbursement" for each funding source per financial exhibit.

Authorized Signature: _____ Phone: _____

Title: _____ Date: _____