

Insert Provider Letterhead

Invoice Date: _____
 Invoice # _____
 Submitted by: _____

Federal Tax ID# _____
 Contract # _____

Provider Site Name

TO: Virginia Department of Health
 Virginia Every Woman's Life (EWL) Program
 109 Governor Street, 8th Floor, West
 Richmond, Virginia 23219
Attention: Data Manager

FEDERAL SCREENING INVOICE

Reimbursement is requested for expenses incurred for:

Expense	Description	Amount Requested	<u>FOR STATE USE ONLY</u>	
			Amount Approved	State Approval
Breast & Cervical Services	Screening, diagnostic and follow-up services (list clients and service dates on Client Screening List)	# Clients _____ \$ _____	# Clients _____ \$ _____	
CHW Support	Funds to support Community Health Worker ¹	\$ _____	\$ _____	
Colorectal Services	Funds to support colorectal screening services ²	# FIT _____ # Colon _____ Travel Reimbursement: # Clients _____	FIT # _____ \$ _____ Colon # _____ \$ _____ Travel \$ _____	
Other		\$ _____	\$ _____	

Send the approved amount to (*enter address in the space below*):

¹ Health Departments do not need to submit an invoice for CHW support.

² Request for colorectal screening services is limited to EWL pilot sites

