Insert Provider Letterhead

Invoice Date: ____________________________ Federal Tax ID#_____________________________
Invoice #________________________________ Contract #__________________________________
Submitted by: ____
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

STATE SCREENING INVOICE

Reimbursement is requested for expenses incurred for:

Expense	**Description**	**Amount Requested**	**FOR STATE USE ONLY**	
			Amount Approved	**State Approval**
Breast & Cervical Services	Diagnostic and follow-up services (list clients and service dates on Client Screening List)	# Clients____________ $__________________	# Clients_________ $_________________	
Other		$	$	

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

Client Screening List – State

Invoice Date: ____________________ Invoice #____________________________

Screening data is submitted for payment on the following EWL clients (**list clients paid with <u>state funds</u>**):

No.	**Client Name**	**Screening Date of Service**	**STATE USE ONLY Approved**

Client Screening List – Follow-Up

No.	Client Name	Screening Date of Service	STATE USE ONLY Approved