INVOICE FOR SOCIALLY NECESSARY SERVICES
BUREAU FOR CHILDREN AND FAMILIES - ASO PAYMENTS
350 CAPITOL STREET ROOM 730
CHARLESTON, WV 25301-3711

Invoice Number: _____
Modified Inv. Number: _____

PROVIDER NAME: _____ CONTACT NAME: _____
FACTS PROVIDER NUMBER: _____ CONTACT NUMBER: _____
EMAIL ADDRESS: _____

AUTHORIZATION NUMBER	PROVIDER STAFF MEMBER PERFORMING SERVICE	MONTH OF SERVICE	FACTS CLIENT ID	CASE NUMBER/ REFERRAL ID	FACTS CLIENT NAME (first name last name)	SERVICE CODE/ TYPE	NUMBER OF UNITS BILLED	UNIT RATE	TOTAL
									$ -
									$ -
									$ -
									$ -
									$ -
									$ -
									$ -
									$ -
									$ -
									$ -
									$ -
									$ -
									$ -
									$ -
									$ -
								INVOICE TOTAL	$ -

I certify to the best of my knowledge, that the services described above were approved, delivered to the client, and that no other payment for these services has been requested. Also, all required information on the services and client has been submitted to the department.

Note: **Correct invoices must be submitted within one year of the date of service. Provider will forfeit payment for failure to submit correct invoices to the Department within one year after the date of service.**

Authorized Agency Representative Signature _____ Date _____

Printed Name _____

FACTS
Entered by:
Date:
Amount:
****** BCF Use Only 08/27/2015 Revised ******