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: _____
FACTS PROVIDER NUMBER: _____

CONTACT NAME: _____
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, on behalf of the social necessary services provider listed above, (1) the services listed herein were authorized and delivered to the client; (2) the services have not been previously billed; and (3) all required reports have been submitted to the caseworker. On behalf of the provider listed above, I agree to repay the Department for any payment for which the provider listed above was not entitled. **Note:** Services must be billed with 30 days of the date of the service. For home studies, clinical reviews, or CAPS reports, the date of the service is the date of submitting the same to the caseworker. Incorrect invoices will be returned to Providers for resolution. If necessary, corrected invoices must be submitted within one year of the date of service. Provider will forfeit payment for failure to submit corrected invoice timely.

FACTS
Entered by:
Date:
Amount:
*** BCF Use Only 06/12/2018 Revised ***

_____
Authorized Agency Representative Signature

_____
Date

_____
Printed Name