



Telehealth Originating Site Facilitation Fee Invoice for Reimbursement

Provider Name: _____

Mailing Address: _____

Monthly Invoice: _____

*** Submit Claim within 30 days after each month**

Mail: Telehealth Coordinator or Tarik Thomas
Senior and Disabilities Services
550 West 8th Ave
Anchorage, AK 99501

Fax: Attention: Telehealth Coordinator;
Telehealth Claim 907-269-3648

Email: tarik.thomas@alaska.gov

Certification:
I certify that to the best of my knowledge and belief, this claim is true and correct in all respects, that records are available to support this claim and that it is in accordance with the terms and conditions of existing agreement.

I understand that failure to submit claims within the 30 day deadline may result in such claims not being paid.**

Date of Initiation:	Clinic Location:	DSDS #	Total
			62.43
			\$ -
			\$ -
			\$ -
			\$ -
			\$ -
			\$ -
			\$ -
Claim Total			

Print Name & Title of Preparer **Date**

Telephone or email contact

Print name of person designated by Provider Agency with authorization to sign:

Authorized Signature

For SDS Use:

Received _____ Postmark Date (if applicable) _____

Data entry-Initial & Date _____ Program Manager _____

rev 02.03.2016 \$0.00 Date _____ Date _____