Invoice/Reimbursement Request 2020-21

Please send this request via e-mail or USPS to:
Matt Crespin, Associate Director
Children's Health Alliance of Wisconsin
(414) 337-4562, telephone
mcrespin@chw.org

Date of invoice: _____

Fiscal agency/Organization: _____
*****Checks will be made out to this entity unless otherwise noted.

Fiscal agent Contact person: _____

Street Address / City / ST / ZIP:_____

Telephone number: _____

Total amount of invoice/reimbursement request(Boxes A-E):

$

Documentation (Comp Report by Program) to support items A – D must accompany all reimbursement requests.

A. Children Screened ($3.50 / unique child screened): $
List the number of unique children screened: _____

B. Sealants ($13.00 / unique child receiving sealants): $
List the number of unique children sealed: _____

C. Fluoride Varnish ($5.00 / unique child receiving two varnish applications in the previous 12 months): $
List the number of unique children receiving two varnish applications in the previous 12 months: _____

D. Data Entry ($5.50 / unique child entered in DentaSeal): $
List the number of unique children entered in DentaSeal _____
(This will be the number of children screened from the program Comp Report)

E. Other / Infection Control Funding: $
*Include copy of invoice/receipts

Authorized fiscal agent signature: _____

Please ensure that requested amounts do not exceed amounts in the approved budget either in total or by category. You will receive payment in 3-4 weeks.