Reimbursement Request

Invoice #_____
Date _____

To: Alabama Department of Public Health
Office of Primary Care and Rural Health
PO Box 303017
Montgomery, AL 36130-3017

Hospital_____

Address_____

City/State_____Zip_____

Invoice for reimbursement for services rendered in fulfilling requirements of the Small Rural Hospital Improvement Grant Program (SHIP) in accordance with the terms of Grant No. C-_____(leave blank)

Itemized Description of Items or Services Purchased (Attach copies of vendor(s) invoice and cancelled check)	Amount Due

TOTAL $

I certify that the items listed on this invoice reflect purchases within the approved agreement and are approved for payment.

_____

AUTHORIZED SIGNATURE