Crossroads Head Start D-213

Billing Invoice For Speech Services

Pathologist's Name:_____ Pathologist's Signature:_____

Date: ____/ ____/ ____ Teacher's Signature: _____

Total Hours: _____ Center: _____

Child's Name (List all children)	Service Performed (Absent, Refused, Treated, etc.)	Time	# of Children

REMINDER: Billing is to be turned in on a monthly basis. Please note children covered by Medicaid.

Rev. 7/31/2022