Broker Invoice

Signing and submitting false information may lead to a charge of Medicaid fraud.

Fiscal Intermediary (FI): Person Centered Care Services	Participant's Name:
Broker's Name:	Participant's Medicaid CIN:
Check one: ____ Independent Broker ____ Agency Broker	Participant's TABS #:
Check one: ____ Start-up Brokerage ____ Support Brokerage	Primary Service Location:

Invoice for the Month/Year of: _____

Put your initials in the "Initials" box below for each date a service was provided. This attests that the service was provided on that day.

Date: Mo/Day	Hrs. Worked From/To	Tot. Hours Charged	Face-to-Face (y/n)	Specify the Broker's Action Provided in Support of a Valued Outcome (service locations may be noted)	Initials
Total Hours Charged:					

Invoice Amount = Total Hours Worked _____ x Hourly Rate $_____ = $ _____

Signature of Broker: _____ Initials: _____ Date: _____

Signature of Family Member/Participant _____ Date: _____

Participant: Original to FI – For FI Use Only – Payroll Authorization_____

Person Centered Care Services
150 Granite Avenue, Staten Island, NY 10303
718-370-1088
www.pccsny.org