Invoice

Texas Children's Health Plan

Date: [Enter a date]
Invoice #: [COPAY_NPI]

TO: Texas Children's Health Plan
6330 West Loop South #800
Bellaire, Texas 77401
Phone 832-828-1008
tchpfinance@texaschildrens.org

FROM: [Provider Name]
[Street Address]
[City, ST ZIP Code]
[Finance Contact Name]
Phone [Contact Number]
NPI [XXXXXX]
Tax ID [XXXXXX]

Service Period	Description	# of Waived Co-payments	Total
3/13/2020 – End of Disaster Declaration	CHIP Co-payment Reimbursement	[XXXX]	$[XXXX]
		Total	$[XXXX]

Note: To ensure timely processing, please complete the attestation below and file all claims with service dates during this waiver period to TCHP before sending this lump sum invoice.

I, _____, certify that the attached invoiced amounts represent office visit co-pays that my practice did not collect for dates of service on March 13, 2020 through the end of the disaster declaration period, for CHIP members in accordance with direction from Texas Health and Human Services.
The above and the attached are true and correct to the best of my knowledge and belief. I know that I may be subject to penalties if I provide false or untrue information. All original documents will be retained and preserved as required by law, and such documents will be submitted, or access to such documents permitted, as required by HHSC or any agency of the state or federal government, or their representative(s).

_____ _____

Signature Date