TN Department of Health

Invoice for DA Vendor Reimbursement

Additional Comments

To be completed by Accounts Management Office:

PO #: _____ Line #: _____ Receipt #: _____ TDH Invoice #: _____

Edison Contract #: _____ Edison Vendor #: _____ Address Line #: _____ Invoice Date: _____

Remit Payment to:

Vendor Name: _____ Street Address: _____ City/State/ZIP: _____

Period of Service: From: _____ To: _____ Type of Service: _____

Service Date	Name	Service Type	Hours Worked	Rate	Total	Speedchart/User Code
Total Due			0.00		$ 0.00	

Vendor's Confirmation and Signature:

☐ I agree by signing this invoice, I understand that I am an independent contractor and not an employee with the State of Tennessee or the Department of Health.

Name: _____ Signature: _____ Date: _____

Contract State Agency's Confirmation and Signature:

☐ I hereby certify the data above to be true and correct and payment is due the above-named vendor.

Name: _____ Signature: _____ Date: _____

Accounts Management Office Signature:

Name: _____ Signature: _____ Date: _____