

DOH Refugee Health Screening Program Invoice for Services Rendered

**New Mexico Human Services Department
Income Support Division
1474 Rodeo Road
P. O. Box 2348
Santa Fe, New Mexico 87504-2348
Attn: Megan Heurion, State Refugee Coordinator**

Contractor **NMDOH**
Date of Service(s)
Invoice Date
Agreement No
Tax ID No
Invoice No

FOR CONTRACTOR USE ONLY

Invoice Amounts

Requested monthly reimbursement for Refugee Health Screening program and administration

\$ -

FUNCTION

AMOUNT

MONTHLY TOTAL

Medical Screening			
Medical Screening Administration			
Administration Planning and Coordination			
TOTAL:			

Agency:	
Business Unit:	
Fund#	Dept#
Account #	Sub-Account #
Reporting Category:	Operating Unit:
Bud Reference:	Class:
Project Code:	Activity Code:

Certification

The undersigned certifies that:

- 1) The amounts invoiced herein are correct and just and that payment therefore has not been received; and
- 2) agree with the attached transmittal invoice.

Agency's CFO Signature

Phone #

Date

REMIT PAYMENT TO:

**DOH/PHD/TB/Refugee Health Program
P. O. Box 26110 (Runnels, S 1150)
Santa Fe, NM 87502**

CERTIFICATION - FOR HSD USE ONLY