<u>ATTACHMENT 3</u>

DOCCS MEDICAL BILL PAYMENT UNIT
CLINIC CLAIM COVER SHEET

Federal Tax ID #: ____

Provider Name: ____

Remit To Address: ____

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Provider Phone #: ____

Total Charges: ____

Date of Service: ____

Place of Service: ____

Clinic Service Type: ____

# of Individuals Seen: ____

Please attach call out sheets to this form <u>IDENTIFYING</u> each incarcerated individual seen.
Call out sheets are available from the correctional facility.
Please use a separate form for <u>EACH</u> clinic.

OMISSION OF ANY OF THIS INFORMATION MAY RESULT IN YOUR INVOICE BEING RETURNED TO YOU!!!

Completed forms should be mailed to the attention of the Medical Bill Payment Unit at the address below. Questions concerning the completion of this form should be directed to 518 408-5215.

NYS Department of Corrections and Community Supervision
The Medical Bill Payment Unit
1220 Washington Ave., The Harriman State Campus
Albany, NY 12226-2050