



Department of Education

Impartial Hearing Order Implementation Unit

INVOICE # _____
CASE # _____

INVOICE DATE : _____

VENDOR NAME _____ Phone #: _____

VENDOR EIN # / SSN # _____

VENDOR ADDRESS _____

EMAIL _____

PROVIDER NAME (If different from vendor name) _____

STUDENT'S NAME _____

STUDENT'S OSIS # _____

STUDENT'S ADDRESS _____

TYPE OF SERVICE _____

DATE OF SERVICE	LENGTH OF SESSION						

TOTAL NUMBER OF SESSIONS : _____ RATE : _____ TOTAL AMOUNT DUE : _____

I hereby certify that I have provided services on the dates and for the duration indicated herein. I understand that when completed and filed, this form becomes a record of the NYC Department of Education (DOE) and is relied upon by the DOE to make payment and any material misrepresentation may subject me to criminal, civil and/or administrative action.

PROVIDER'S SIGNATURE : _____ DATE: _____

By my signature, I acknowledge that I have reviewed this billing form and that, to the best of my knowledge, these sessions were provided as indicated

PARENT / PRINCIPAL'S SIGNATURE : _____ DATE : _____

SUBMIT ORIGINAL INVOICES TO

**N.Y.C. Department of Education
Impartial Hearing Order Implementation Unit
65 Court Street – Room 1503
Brooklyn, NY 11201**

PLEASE NOTE: ALL FIELDS MUST BE COMPLETED