

**KCDDD  
Hearing Aide  
BILLING INVOICE**

**Agency Name: Children's Clinic "A"**  
**Address: 123 "B" ST**  
 Seattle, WA 12345  
**Telephone: 123-456-7891**

**Month: Sept-2003**  
**Client Name: Baby Jones**  
**Audiologist: J.A. Smith**

#	Describe Expenditures	Unit Price	Quantity	Total Amount	Note
1	Hearing Aide Aero 211 AZ	\$895.00	2	\$1,790.00	Digital BTE Hearing Aide III Biaural
2	Earmolds	\$45.00	2	\$90.00	Monaural (rt & lt)
3	Other Services Flat Fee	\$500.00	1	\$500.00	
4				\$0.00	
5				\$0.00	
6				\$0.00	
7				\$0.00	
8				\$0.00	
9				\$0.00	
10				\$0.00	
11				\$0.00	
12				\$0.00	
13				\$0.00	
14				\$0.00	
15				\$0.00	
	<b>Total</b>			<b>\$2,380.00</b>	

**Child's file must contain documentation that the items billed for were provided.**

**Hearing Aid Reimbursements require preapproval  
via King County DDD's Extraordinary Expense procedure.**

**King County Vendor's Certificate**

I hereby certify under penalty of perjury that the items and total listed herein are proper charges for materials, merchandise or services furnished to King County, and that all goods furnished and/or services rendered have been provided without discrimination because of age, sex, marital status, race, creed, color, national origin, handicap, religion, sexual orientation, or Vietnam era or disabled veterans status.

Prepared by: \_\_\_\_\_

Date: \_\_\_\_\_

PRINT NAME & TITLE

SIGNATURE