REHAB ACTION, INC

Invoice

Therapist's Name:

Week:

Patient Name	Company	SUN	M	T	W	Th	F	SAT	NOTES
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
16									
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18									
19									
20									

Please email or fax (727-232-0685) weekly invoice for all **NON-devero** patients.

Payment for invoices received **after Monday 9AM for previous work week** will be delayed an additional 2 weeks.

TX = TREATMENT MV= MISSED VISIT E = EVAL RA=REASSESMENT DC = DISCHARGE

SOC = START OF CARE OASIS RC = RECERT OAISIS ROC = RESUMPTION OF CARE OASIS