Providers VAX Secure Invoice Upload

Tracking Number: 583

Date: 5/29/2021

Contract Information

Please enter the conract number first to automatically populate the fields listed with an asterisk (*) Please note that these fields are "Read Only" and edits are not permitted on the form.

OTH-VAX-538	Ember Modern Medicine	84-4044647	7000296089
Contract Number (required)	* Contractor Name	* Tax ID	* SCEIS Number

Brian Blank	Owner	(864) 608-6698		brianblank@embermodernmedicine.
Contact (Full Name)	Title	Phone	EXT	Contact EMAIL

1068 North Church Street		Greenville	SC	29601
* Address	* STE #	* City	* State	* Zip

INVOICE NUMBER	INVOICE AMOUNT
3	2,370.00

Please Upload Invoice for Payment Review

To ensure prompt processing of your invoice ensure that you include the invoice number in the file name that you upload. Please ensure that all required information is included on the invoice. Click below for more details

Secure Document Upload

Please upload the invoice PDF to our secure website using the bu ons below.

COVID19 Vaccine Reimbursement Requests 5-28-21 Invoice 3

☑ I certify that no other funds have been received or will be reimbursed by any other source for the amounts claimed on this invoice

Signature (required) Click to Sign

Brian Blank
5/29/2021 2:26:48 PM

$2,370.00
Invoice Total

◉ Yes
○ No

The attached invoice is acurate and the invoice total is correct.

ACC Testing Approval

Bonner, Melissa
6/1/2021 6:27:21 AM

Budget and Finance Approval

Samuels, Tierra B.
6/9/2021 12:51:45 PM

Approved Funding

Approved Invoices to Date

Availible Funding **$0.00**

Payment Processing Instructions

31070000 Not Relevant J0402AZ998 J040X01058580130
5021310000 98000018 Full Amount $2,370

Accounts Payable Approval

Robinson, Sharon D.
6/10/2021 2:19:52 PM

If rejecting this form for any reason please provide a brief note to the agency. It will be included in the rejection email notification

COVID-19 Vaccination Reimbursement Request

Inv. 3

Community Vaccination Event Information*

R _____

RM _____

R BRM _____

A UU T I _____

I _____

RU V V _____

U _____

BM U _____

Please fill in the green cells in this document to calculate the eligible reimbursement for your event. This form will need to be submitted in the invoice portal either as a PDF or XLSX file for each testing event.

Please select yes or no to the following questions to determine eligible reimbursement:

U V T R R U U U

U V T RU U U

U V T U U

Reimbursement Calculator

Item	Rate	Eligible Event Reimbursement
B R U U		
ARU I		
I		
Total Event Reimbursement Amount		**$2,370**

Additional Cost Summary***:

U _____

UU RM UR

U **$0**

Total Request Amount: $2,370

RRV B U R V UT RT VU U U RU UR A
U U M UT

U TV RM UR U U U TT T UM
U M RM UR M TV T V U U UM V U
M U RM UR M I RM UR

R U U U PU R U U U
U U

IRR V UT U U U
UM I I I B U
U M RU U
UM U RU T
U U M M V V U U U T
U U M U U A U U T