

Loan Repayment Invoice for Payment

Health Care Provider Incentives Program

Tina Kotek, Governor



OREGON
HEALTH
AUTHORITY

OREGON OFFICE
ORH
of RURAL HEALTH

Provider name: _____

Contract number: _____

Qualified practice site name: _____

Provider Service Hours: ☐ Full-time (minimum of 32 hours per week of direct patient care)
 ☐ Part-time (minimum of 16 hours per week of direct patient care)

Direct patient care includes activities such as charting, medication management, follow-ups, and consultations.

Quarterly disbursement amount request:

Please pay \$[_____] for fulfillment of the Provider's previous quarterly service commitment as part of the Loan Repayment Program.

Please Note the following:

- If the Provider received a program disbursement in the previous quarter, this invoice must be accompanied with a Payment Confirmation Form and any additional required documentation as outlined by the Oregon Office of Rural Health (ORH).
- Submission of completed invoice and previous Payment Confirmation Form are required to issue quarterly disbursement payment by the Oregon Health Authority (OHA).
- Invoices are submitted to OHA in accordance with the Incentive Payment Period stated in Section 2.02 of the Provider contract agreement. It can take up to 60 days for OHA to process invoices and issue payments.
- If this is the Providers first disbursement payment, payment may be issued by paper check and mailed to the physical address listed on the Provider contract agreement. All future payments will be made by direct deposit, unless otherwise indicated by the Provider.
- **To avoid any delays in payment, please notify ORH immediately of any changes to the provider's contact information or banking information at ruralworkforce@ohsu.edu**

Provider signature: _____

Date: _____

For ORH office use only: ____ of 12