

HOSPITAL LETTERHEAD

Invoice No. 1234

DATE

Contract Manager's Name  
Florida Department of Health  
Division of Emergency Medical Operations  
4052 Bald Cypress Way, Bin A-23  
Tallahassee, FL 32399-1746

**RE: HPP Contract COP ??**

Dear [insert Contract Manager's name]:

We are requesting reimbursement for Deliverable # [Insert deliverable number here] that has been purchased, in the amount of \$xx,xxx.xx in accordance with the terms of our contract.

I further certify the goods have been received.

Please remit payment to: **Legal Name of Hospital as it appears on Part A and in MyFloridaMarketPlace Anywhere, Florida 12356 (must also match Part A and MFMP exactly)**

Sincerely,

**SIGNATURE REQUIRED**

John Doe  
Director of Safety Operations

Enclosure: Vendor Invoices  
Proof of Payment  
MBE Expenditure Report (Attachment IV)