

**Statement of Screening Services 2007  
 Colorado Colorectal Screening Program  
 Fax to (303) 724-0648**

**Provider:**

Name  
 Address  
 City, State Zip  
 Phone Number  
 Fax No.

**CHC:** Name

**Services Provided:** Anesthesia

**Dates of Services Provided**

**From:**

**To:**

**Date Submitted:**

**Prepared by:**

Quantity	Descript of Services	Rate	Amount Due
	5 Base Units & Time		\$ -
<b>Total Amount Due</b>			<b>\$ -</b>

Please attach the "Certification of Verification" provided by CHC: \_\_\_\_\_ when submitting this Statement of Screening Services.