ILLINOIS DEPARTMENT OF HUMAN SERVICES
Division of Alcoholism and Substance Abuse
AUTOMATED REPORTING AND TRACKING SYSTEM
TOXICOLOGY SERVICES

PROVIDER: [__________]
UNIT: [__________] PROGRAM: [______]
YEAR: [__________]
MONTH: [______]

PATIENT #1
Funding Indicator: [D C]
Unique Patient Identifier: [______________]
Billing Begin Date: [______] / [______] / [______]
Toxicology Tests: [______]
Revision Code: [______]

Dedicated Funding Category: SELECT ONLY ONE
☐ D = DCFS
☐ G = OMT Toxicology
☐ N = None
☐ O = OMT-STR

PATIENT #2
Funding Indicator: [D C]
Unique Patient Identifier: [______________]
Billing Begin Date: [______] / [______] / [______]
Toxicology Tests: [______]
Revision Code: [______]

Dedicated Funding Category: SELECT ONLY ONE
☐ D = DCFS
☐ G = OMT Toxicology
☐ N = None
☐ O = OMT-STR

EFFECTIVE 07/01/17 – 06/30/18