ILLINOIS DEPARTMENT OF HUMAN SERVICES
Division of Substance Use Prevention and Recovery
AUTOMATED REPORTING AND TRACKING SYSTEM
TOXICOLOGY SERVICES

PROVIDER: [__________]  YEAR: [__________]
UNIT: [__________]  PROGRAM: [______]  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 07/01/2019 – 06/30/2020