PROVIDER: [_________]
UNIT: [_________]
PROGRAM: [_______]

SITE NUMBER: [_______]

STAFF ID: [_________________]
SERVICE DATE: [____ / ____ / ____]

PATIENT #1
Funding Code: [_____] Unique Patient Identifier: [____________________]
Service Type: [_____] Activity Code: [_____] Group ID: [__________]
Start Time: [_____] : [_____] am/pm Length of Service: [_____] Hrs: [_____] Mins: [_____] Collateral ID: [___________________]
Telehealth: [____]

Medicaid Billing Data
Spend Down: [_____] [____]

TPL Information
TPL Status: [_____] TPL Payer Amount: [_____] [____]
TPL Paid Date: [_____] / [_____] / [_____

Dedicated Funding Category: SELECT ONLY ONE
☐ D = DCFS
☐ L = Gambling
☐ N = None

PATIENT #2
Funding Code: [_____] Unique Patient Identifier: [____________________]
Service Type: [_____] Activity Code: [_____] Group ID: [__________]
Start Time: [_____] : [_____] am/pm Length of Service: [_____] Hrs: [_____] Mins: [_____] Collateral ID: [___________________]
Telehealth: [____]

Medicaid Billing Data
Spend Down: [_____] [____]

TPL Information
TPL Status: [_____] TPL Payer Amount: [_____] [____]
TPL Paid Date: [_____] / [_____] / [_____

Dedicated Funding Category: SELECT ONLY ONE
☐ D = DCFS
☐ L = Gambling
☐ N = None

EFFECTIVE 07/01/2020 – 06/30/2021