PROVIDER: ____

UNIT: ____ PROGRAM: ____

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

YEAR: ____

MONTH: ____

PATIENT #1

Funding Code: ____ Unique Patient Identifier: ____

Billing Begin Date: ____ / ____ / ____

Billing End Date: ____ / ____ / ____ Psychiatric Eval. Bill: ____

Telehealth: ____

Medicaid Billing Data Due from Patient (Spend Down): ____ • ____

TPL Information Status: ____ Payer Amount: ____ • ____

Paid Date: ____ / ____ / ____

☐ D = DCFS
☐ N = None

PATIENT #2

Funding Code: ____ Unique Patient Identifier: ____

Billing Begin Date: ____ / ____ / ____

Billing End Date: ____ / ____ / ____ Psychiatric Eval. Bill: ____

Telehealth: ____

Medicaid Billing Data Due from Patient (Spend Down): ____ • ____

TPL Information Status: ____ Payer Amount: ____ • ____

Paid Date: ____ / ____ / ____

☐ D = DCFS
☐ N = None