SUPERBILL

Psychotherapy Services

Date of Issue: Invoice #:

Provider Information

Provider Name: License Type & #: NPI #: Tax ID / EIN: Address: Phone:

Patient Information

Patient Name: Date of Birth: Address: Insurance ID #:

Clinical Information

ICD-10 Diagnosis Code(s):
Diagnosis Description:

Date of Service	CPT Code	Description	Place of Service	Fee
			Total Amount Paid:	

Provider Signature: _____

Payment Status: Paid in Full

This document is intended for the purpose of insurance reimbursement. It contains protected health information.