

PEDIATRIC BEHAVIORAL HEALTH

[Provider/Clinic Name]

[Address / Phone]

[NPI / Tax ID]

INVOICE

INVOICE #

DATE

PATIENT INFORMATION

Name:

DOB:

Parent/Guardian:

BILLING / INSURANCE

Carrier:

Policy ID:

Authorization #:

Date of Service	CPT Code	Description of Services	Fee

Subtotal: \$ _____

Insurance Adjustment/Paid: (\$ _____)

Total Balance Due: \$ _____

Notes: Please include the patient name and invoice number with your payment. Thank you for choosing our practice for your child's developmental and behavioral needs.

Diagnosis Codes (ICD-10): _____