EMERGENCY PSYCHIATRIC ASSESSMENT INVOICE

Invoice #
Date

Provider/Facility Information
Name:

NPI/Tax ID:

Address:

Phone:

Patient Information
Full Name:

Date of Birth:

Patient ID/MRN:

Insurance Policy #:

Assessment Details
Admissions Date/Time:

Discharge Date/Time:

Referring Physician/Agency:

CPT Code	Description of Services (Psychiatric Evaluation/Crisis Intervention)	Units	Unit Cost	Total

Subtotal: $_____

Total Due: $_____

Diagnosis Codes (ICD-10)
Primary:

Secondary:

Confidential Medical Record - HIPAA Compliant Document

Payment Terms: Due upon receipt. Please make checks payable to the provider listed above.