PSYCHIATRIC CONSULTATION SERVICE

[Hospital Name]
[Department Address]
[Phone Number / Email]

INVOICE

Date: _____
Invoice #: _____

PATIENT INFORMATION

Name:
DOB:
Medical Record #:
Admission Date:

BILLING / INSURANCE DETAILS

Payer:
Policy #:
Provider NPI:
Case Manager:

Date of Service	CPT Code	Description of Consultation / Evaluation	Unit/Hrs	Rate	Total
		Initial Psychiatric Evaluation			
		Follow-up Consultation / Med Management			
		Emergency Crisis Intervention			
		Formal Neuropsychological Testing			

Subtotal: $_____
Adjustments/Insurance Credit: ($_____)

TOTAL BALANCE DUE: $_____

Please make all checks payable to **[Hospital Name / Physician Group]**

Confidential Medical Billing Document - HIPAA Compliant