Telehealth Psychiatric Services

[Provider Name / Practice Name]
[NPI Number]
[Address / Digital Contact]
[Phone Number]

INVOICE

Invoice #: _____
Date: _____

BILL TO:

[Patient Full Name]
[Patient Address]
[Patient DOB]

INSURANCE INFO:

[Insurance Carrier]
[Member ID / Group ID]
[Authorization # if applicable]

Date of Service	CPT Code	Description of Service	Amount
_____	90792	Psychiatric Diagnostic Evaluation with Medical Services (Telehealth)	$ _____
_____	[Add Code]	[Interactive Complexity / Add-on Code]	$ _____

Date of Service	CPT Code	Description of Service	Amount

Total Balance Due: $ _____

Clinical Notes / Place of Service:

Place of Service Code: 02 (Telehealth Provided Other than in Patient's Home) or 10 (Telehealth Provided in Patient's Home)

Payment Instructions: Please make checks payable to [Practice Name] or pay via [Payment Portal Link].

This document serves as a billing statement for psychiatric services rendered via secure telecommunication. Confidentiality of medical information is protected by HIPAA.