Billing form for Targeted Case Management Services

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or write N/A if not applicable

Clinical Supervisor \_\_Sameera Chowdary, LPCA, KY 0732\_\_\_ NPI#1902229982

Billing Supervisor -Deborah Holladay LPCC, KY1066- NPI#1346333911 Medicaid #7100269670

Write in end date of month of service.

 Circle and/or write in the insurance company name:

Passport Humana Caresource Wellcare MHNet Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| End Date | Units | CPT Code | Description of Services |
|  | 1 | T2023 | Targeted Case Management-SED/SMI |