Approval for Services

	P.A. Number
PA Modifier	2431740

Provider
Provider BHP, under clinical supervision 1000 Known St Louisville, KY 00000
Clinical Supervisor

Client
Jane Doe / Medicaid # Address Address MCO ID# / Phone # DOB - Sex - Diag. code

Prof. License Exp.	Prof. Insurance Exp.
Masters/ MFTA	11/11/11

Date span in which services may be provided →

Start Date	End Date
1/1/2013	2/28/13

		Item	Description	Qty	Rate	Customer	Amount
Date of Services	Units Used	Procedure					
1-5-3	8	H0004	Individual/Collateral Therapy - In Home	144	15.00	Doe Jane	2,160.00
1-8-13	10	H0004					

Contractor Signature & Date — your signature, credentials, and date

Total $2,160.00

Diagnosis code # | Is this Service Plan in Chart? | Is client currently in DCBS care? Circle Yes or No

This form does not guarantee payment of services. Active insurance coverage is your responsibility.

this information is required to process billing