DSCYF Department of Services for Children, Youth & Their Families | PREVENTION & BEHAVIORAL HEALTH SERVICES

Non-Residential Services / Activity Billing Summary Form

A copy of this summary form MUST be included on the top of each monthly billing submission

Date of Bill _____ Provider Name _____

Check One:

- ☐ Outpatient
- ☐ MST
- ☐ Day Tx
- ☐ Inpatient
- ☐ Outpatient-FFT
- ☐ DBT
- ☐ PHP
- ☐ Crisis
- ☐ TSF
- ☐ FBMHS
- ☐ Residential

Person Preparing Bill/Activity Report _____

For Services Rendered in the Month of _____20___

Number of client fee sheets submitted this month	
Total number of clients seen this month	
Number of clients admitted this month	
Number of clients discharged this month	
Total Amount Due This Invoice	**$**