State of Delaware
The Department of Services For Children, Youth and Their Families

Division of Prevention and Behavioral Health Services

Claim Form

Client Name:	**DOB:**	**Primary DSM V (Code):**
Provider Name:	**Primary Therapist:**	

Program:

☐ Outpatient ☐ TSF ☐ OP- FFT ☐ MST ☐ DBT ☐ FBMHS

☐ Day Treatment ☐ PHP ☐ Inpatient ☐ Residential ☐ Crisis

Authorization Date:		**Billing Dates:**	
From	*To*	*From*	*To*
Admission Date:		**Authorization Number:**	

SERVICE DATE	SERVICE LOCATION CODE	CPT/HCPCS CODE	UNIT	AMOUNT
			TOTALS	

Total number of un-billable indirect services (case management) provided for this client in this month _____.
These must be documented in the client file.