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: *From* / *To*	**Billing Dates:** *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.