

## Psychiatric Services Billing Statement

### Billing

Provider Name \_\_\_\_\_ Client Name \_\_\_\_\_ FamLink Case ID \_\_\_\_\_

Provider Address \_\_\_\_\_ FamLink Provider ID \_\_\_\_\_ Provider Phone \_\_\_\_\_

DCYF Case Worker \_\_\_\_\_ DCYF Office \_\_\_\_\_ Case Worker Phone \_\_\_\_\_

Month of Service \_\_\_\_\_ Year \_\_\_\_\_ Client Phone \_\_\_\_\_

Services Provided	Level	Units of Service	Amount Billed	Total Due
Diagnostic Evaluation (with written reports) <b>**1 Unit = hours</b>				
Parental Evaluation/Parenting Component (Conducted in addition to Diagnostic Evaluation) <b>**1 Unit = hours</b>				
Psychotherapy with Report (with written report) <b>**1 Unit = 30 minutes</b>				
Medication Management (with report) <b>**1 Unit = 30 minutes</b>				
Professional Consultation with DCYF staff or other authorized parties (with report) <b>**1 Unit = 30 minutes</b>				
Case Related Travel (Per hour, per person) Contractor must attached written pre-authorization from DCYF for more than 1 hour of travel <b>**1 Unit = 15 minutes (units of service autopopulates from travel log)</b>			\$ 12.53	

Allowed hours & Rates cannot exceed what DCYF authorized.

**Total**

### Comments

Include a copy of the signed referral and the final report with this invoice.

### Provider's Certification

I hereby certify under penalty of perjury that the invoice above is correct and are the proper charges for services furnished to the State of WA DCYF.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Travel Log for**

**Total Number of Units**

Date of Service	Staff Name	Start Time AM/PM	End Time AM/PM	Units (1 unit is 15 minutes)	From Address	To Address	Purpose of Trip

**Service Log**

**Total Number of Hours**

Date of Service	Description of Service/Tasks	Hours