CDS-Cumberland Billing Form

50 Depot Road, Falmouth, ME 04105 781-8881, ext. 205 or 222

Provider Name:_____ **Invoice Date:**_____
Address:_____ **Invoice No.:**_____
_____ **EIN/SSN:**_____
Phone No.:_____ **Fax No.:**_____ **E Mail:**_____

Child's Information

Name:_____ **DOB:**_____
Date IFSP Began:_____**Date IFSP Ends:**_____ **Funding Source: INS** _____**MED**_____**CDS**_____
Usual & Customary Rate:_____

Please indicate billing units: _____15 min units _____30 min units ____60 min units

Service Dates	Make-up Session	Description of Service	# of *Units or DT Sessions	Unit Rate	Service Total	Travel Time/Units*	Travel Rate	Travel Total	Total
		Total Amount Due:							

Provider must bill CDS/Cumberland within 30 days of service delivery and/or travel time unless a 3rd party is being billed.
Submissions must be prompt.
Please attach any insurance or medicaid explanations of benefits to this bill.
To receive payment, provider must forward quarterly progress notes by the end of each quarter.
Date that progress notes were forwarded to CDS/Cumberland:_____

*** See Travel Schedule and/or CDS sample bill.** **NOTE: ECT travel is not reimbursable.**

Signature:_____ **Date:**_____