

CDS-Cumberland SAMPLE Billing Form
50 Depot Road, Falmouth, ME 04105 781-8881, ext. 205 or 222

Provider Name: Jane Doe
Address: 442 Glenwood Ave.
Portland, ME 04103
Phone No.: 634-5789 Fax No.: 634-5799 E Mail: jdoe@blah.net

Invoice Date: 6/1/02
Invoice No.: 2525
EIN/SSN: 012-345-6789

Child's Information

Name: John Smith DOB: 7/1/99
Date IFSP Began: 4/1/02 Date IFSP Ends: 3/31/03 Funding Source: INS MED CDS X
Usual & Customary Rate: 75.00

Please indicate billing units: 15 min units 30 min units X 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
5/6/02		Speech Therapy	1	47.00	47.00	0.50	23.50	11.75	58.75
5/7/02	4/12/02	Speech Therapy	1	47.00	47.00	0.50	23.50	11.75	58.75
5/9/02		Speech Therapy	1	47.00	47.00	0.50	23.50	11.75	58.75
5/13/02		Speech Therapy	1	47.00	47.00	0.50	23.50	11.75	58.75
5/16/02		Speech Therapy	1	47.00	47.00	0.50	23.50	11.75	58.75
5/17/02		ECT	0.5	47.00	23.50	*	23.50		23.50
5/20/02		Speech Therapy	1	47.00	47.00	0.50	23.50	11.75	58.75
5/23/02		Speech Therapy	1	47.00	47.00	0.50	23.50	11.75	58.75
5/28/02		Speech Therapy	1	47.00	47.00	0.75	23.50	17.63	64.63
5/30/02		Consultation	0.5	47.00	23.50	0.50	23.50	11.75	35.25
5/31/02		Collateral Contact	0.25	47.00	11.75	0.50	23.50	11.75	23.50
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					-			-	-
					-			-	-
Total Amount Due:									\$ 558.13

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: 06/01/02