

Therapist Name		_ Discipline _		Invoice Number	
Facilty Name/Service Site		_		Service Month	
Date of Service	Patient Name	Patient ID	Type of Visit (OIG/IE/PN/D/C	Documentation Type (Manual/E and Enclosure HEP/NOMNC,	
/ /					\$
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	Total Number of Visits			Total A	mount \$
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Clinician Signature	Approver Name		Facility Approval S	Signature	Date Signed