"PRESERVATION OF SELF AND COMMUNITY"
ALL WALKS OF LIFE

*Clinician must verify pre-authorization for ALL services

Uniform Service Ticket
FAMILY / GROUP

On-Site: ____ Off-Site: ____ In School: ____

check all that apply → Baltimore? **YES** Medicare? **YES** Prince George's County? **YES**

Clinical Program: (*check one*) ☐ OMHC ☐ PRP ☐ Substance Abuse

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***Date of Service:** ____/____/ 2019

Service(s) Provided:

SERVICE DESCRIPTION		START TIME	END TIME
90847	Family Therapy w/Client Present, 45 minutes	____:____am/pm	____:____am/pm
	Name of Primary Client: _____		
	DSM - V Diagnosis(es) – Primary Client: _____ Diagnosis #1 _____ Diagnosis #2		
	Demographic – Primary Client: (*check one*) ☐ Adult ☐ Child/Adolescent		
90849-52	Multiple Family Group Therapy, 30 minutes	____:____am/pm	____:____am/pm
90853	Group Therapy (non-family), 60 minutes	____:____am/pm	____:____am/pm
H0005	Alcohol & Drug: Group Session, 60 - 90 minutes **No more than 1 group session per day*	____:____am/pm	____:____am/pm

Participant List & Signatures:

- List the names of other family members present in the session; OR
- List the names of participants in the (non-family) group therapy session.

NAME	*SIGNATURE* ← BLUE INK
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature:

PROVIDER *I am providing my signature as confirmation that I personally rendered the service(s) listed above.*

Provider Name: _____

Provider Signature and Credentials: _____

→ office use only ←

CM: *on invoice?* Y N *note submitted?* Y N **BILLING:** *date received:* ____/____/19 *date billed:* ____/____/19