***WEEKLY INVOICE***

***Service Month /Yr:***  ***Week Ending: 1 of 1***

***Consultant Name:***

***Bill To: Greater Malden Behavioral Health.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attention: Billing Department***

***6 Pleasant St, Malden MA 02148***

Please Note: ***One Consumer Per Page***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Client Name  First & Last  D.O.B | GMBH MIS # | Insurance | Date of Service | Type of Service | # of Units | **Billing Purpose Only** |
| 1 |  |  |  |  | IHT-HOIHT-BA  CSP OPD  TM |  |  |
| 2 |  |  |  |  | IHT-HO  IHT-BA  CSP OPD TM |  |  |
| 3 |  |  |  |  | IHT-HO  IHT-BA  CSP OPD  TM |  |  |
| 4 |  |  |  |  | IHT-HO ⁭ IHT-BA ⁭CSP ⁭OPD⁭ TM |  |  |
| 5 |  |  |  |  | IHT-HO  IHT-BA ⁭CSP ⁭OPD ⁭ TM |  |  |
| 6 |  |  |  |  | ⁭ IHT-HO ⁭ IHT-HN  CSP OPD ⁭ TM |  |  |
| 7 |  |  |  |  | ⁭ IHT-HO ⁭IHT-HN CSP ⁭OPD  TM |  |  |
| 8 |  |  |  |  | IHT-HO IHT-HN ⁭CSP ⁭OPD ⁭ TM |  |  |
| 9 |  |  |  |  | IHT-HO IHT-HN ⁭CSP ⁭OPD ⁭ TM |  |  |
| 10 |  |  |  |  | IHT-HO IHT-HN CSP ⁭OPD ⁭ TM |  |  |
| 11 |  |  |  |  | IHT-HO ⁭IHT-HN CSP ⁭OPD ⁭TM |  |  |
| 12 |  |  |  |  | IHT-HO IHT-HN CSP OPD ⁭TM |  |  |
| 13 |  |  |  |  | ⁭ IHT-HO  IHT-HN CSP ⁭OPD ⁭ TM |  |  |
| 14 |  |  |  |  | IHT-HO ⁭IHT-HN ⁭CSP ⁭OPD ⁭ TM |  |  |
| 15 |  |  |  |  | IHT-HO ⁭ IHT-HN ⁭CSP OPD ⁭ TM |  |  |
| ***By signing below, I certify and acknowledge that this document is an accurate representation or the work provided to or on behalf of the above named organization, individual or entity.***  **Provider Signature:** **Date:** | | | | | | | |
| **Finance Signature:** **Date:** | | | | | | | |
| **NOTES** | | | | | | | |