SUPERBILL

CLIENT INFORMATION

Client Name: _____ DOB: ____/____/____

Name of Policy Holder: _____ DOB: ____/____/____

Name of Insurance Plan: _____ Plan ID#: _____

PROVIDER INFORMATION

Provider Name: _____ Degree: _____

License Type & Number: _____ NPI: _____

Provider Federal Tax ID: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

SERVICE INFORMATION

Date of Service	Procedure/CPT Code	Fee	Amt. Paid	Amt. Due
___/____/____	_____	_____	_____	_____
___/____/____	_____	_____	_____	_____
___/____/____	_____	_____	_____	_____
___/____/____	_____	_____	_____	_____
___/____/____	_____	_____	_____	_____
___/____/____	_____	_____	_____	_____
		Total:	_____	_____

Client Diagnosis: _____ (ICD-10 Code#)

Provider Signature: _____ Date: ____/____/____