

# ADULT FORENSIC SERVICES INVOICE

Attachment D

Community Mental Health Center \_\_\_\_\_ Center # \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

	Name of Service Recipient	Social Security Number	Date Evaluation Completed (court letter)	Comprehensive or Screening Evaluation (C or S)	Service Provided (A - J)	Amount Billed	Amount Approved for Payment by TDMHDD (For TDMHDD use only)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
<b>TOTAL THIS PAGE</b>							

\_\_\_\_\_  
 Name of Person Submitting Claim (Please Print)      Date      Phone Number

\_\_\_\_\_  
 Name of Forensic Coordinator

\_\_\_\_\_  
 TDMHDD Forensic Services Approval      Date

- A=Competency Only
- B=Mental Condition Only
- C=Both Competency and Mental Condition
- D= DOC eval. For comp. and/or mental condition
- E= Additional Mental Health Assessment
- F=Physician Services (MD services or evaluation participation)
- G=Pre-hospitalization comp. training (Limit 2)
- H=Post hospitalization comp. training - misdemeanor
- I=Post hospitalization comp. training - felony
- J=Post conviction eval. under -301(a)(4)