INPATIENT JUVENILE SERVICES INVOICE

Facility_____ _____ _____
Month Year

	Name of Service Recipient	Social Security Number	Admission Date	Discharge Date	Length of Stay (# of days)	Amount Billed	Amount Approved for Payment by TDMH (For TDMH use only)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
				TOTAL THIS PAGE			

_____

Inpatient Forensic Coordinator/Financial or Reimbursement Representative **Date**

TDMH Forensic Services Approval **Date**

MH5257 (Rev. 7/11)