

ADULT FORENSIC SERVICES INVOICE

Attachment C

Community Mental Health Center

Center #

Month

Year

Name of Service Recipient	Social Security Number	Date Evaluation Completed (court letter)	Service Provided (A - T)	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					

Name of Person Submitting Claim (Please Print)

Date

Phone Number

Name of Forensic Coordinator

TDMH Forensic Services Approval

Date

- A = Competency
- B = Mental Condition
- DC = DOC eval. For comp. and/or mental condition
- E = Additional Mental Health Assessment
- F = Physician Services (MD services or evaluation participation)
- J = Post conviction eval. under -301(a)(4)
- K = NGRI Committability under -303(a)
- L = Outpatient Treatment Planning -303(a)
- T = Competency Training (any type)