

INSURANCE BILLING UNIT
PARTICIPANT ENCOUNTER FORM

PLEASE NOTE: If the participant has not been approved for insurance billing, the insurance billing unit cannot accept this form.

Provider Name:	Jane Smith RPT	Provider Email Address:	jsmith@myoffice.com
Associate Name: (if applicable)		Payee Name:	Jane Smith
Telephone:	(217) 123-4567		
Child's Name:	John Doe	Child's EI:	123456
Date of Service:	7/1/08	Service Location:	12
Service Start Time:	10:00 am	Service End Time:	11:00 am

Category of Service Provided (check only 1 per form completed)

Units: 1 = 15 mins, 2 = 30 mins, 3 = 45 mins, 4 = 60 mins, etc.

	Total \$ Billed	Units		Total \$ Billed	Units
Assistive Technology			Occupational Therapy		
Audiology			Physical Therapy	\$200	4
Aural Rehabilitation			Psychology		
Developmental Therapy			Social Work		
Medical Diagnostic			Speech Therapy		
Nursing			Vision		
Nutrition					
Other Service Not Listed Above:					
IFSP Outcome to be Addressed:					
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PLEASE ATTACH PROGRESS/OFFICE NOTES

Documentation of visit: John is a 2 year old child who has been diagnosed with Down's Syndrome. I have been asked to work with him regarding his problems with joint instability and that is what we will address at today's session. John was very receptive to the Therapy and tolerated the visit well. I worked with the child on strength building and balance exercises and taught the parent exercises that they could do at home to continue working on balance and strength building. I would like to see the child once per week on a continuing basis and have discussed this with the child's parents.

Provider's Signature:

Parent's Signature:

For EI-CBO Insurance Billing Unit Use Only:

Date Received:

Provider Follow Up Date:

Submission of this encounter form to the Early Intervention Central Billing Office Insurance Billing Unit certifies that the activities identified above occurred at the date, time, location and duration indicated above.