Speech Therapy Superbill

Provider Information

Provider Name:	NPI #:
License #:	Tax ID #:
Phone #:	State License #:
Street Address:	City, State, Zip:

Client / Patient Information

Patient:	DOB:
Account #:	Referring Physician:
Street Address:	City, State, Zip:

Insurance Plan:	Policy #:
Policy Holder:	Date Initial Symptom:
Place of Service:	Date First Consultation:

Diagnosis

Primary (Speech-Language Pathology):	ICD-10 Code:
Secondary (Medical):	ICD-10 Code:
Additional:	ICD-10 Code:
Additional:	ICD-10 Code:

Services

Date	Service	CPT Code	Charge	Amount Paid	Amount Due

Provider Signature:	Date:

Billing Information

Today's Charges:	$
Previous Balance:	$
Total Due:	**$**
Paid Today:	$

Payment Method: _____

Balance:	**$**

Authorizations

I hereby authorize direct payment of benefits to **Practice Name Here** .

SIGNATURE: _____ DATE: _____

I hereby authorize **Practice Name Here** to release any information acquired in the course of treatment.

SIGNATURE: _____ DATE: _____

SLP's Full Name, Degree, CCC-SLP
PRACTICE NAME
Street Address
City, State, Zip
Email | Phone | Fax