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| DDAP-EFM-1006 12/15 | | | | | | **Services Rendered** (i.e., Encounters)  (Required fields are in **BOLD**) | | | | | | | **Provider Location:**  **Provider Name:**  **DDAP License #:** | | | | | | | | | | | | | | |
| **UCN:** | | |  | | | | | | | | | | | | **Date:** | |  | | | | | | | | | |  |
| **First Name:** | | |  | | | | | M.I.: | |  | **Last Name:** | | |  | | | | | | Suffix: | |  | | | |  | |
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| **Service Rendered** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Authorization #: #:** | | |  | | | | | | | | | | | |  | **Final:** Billed: | | Yes  No | | | | | | | | |  |
| Clinician: | | |  | | | | | | | | | | | |  | | | | | | | | | | | | |
| Client Diagnosis**:** | | | |  | | | | | | | | | | | | | | | | | | | | | | |  |
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| **Service Start Date:** | **Service Start Time:** | | | | **Service End Date:** | | **Service End Time:** | | **Authorized Services Rendered** | | | | | | | | | | **Units** | | | | | **UOM** | | | |
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| Comments: | |  | | | | | | | | | | | | | | | | | | | | | | | | |  |

Form to be submitted to SCA if required by the SCA.