|  |  |  |
| --- | --- | --- |
| 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: |       |  |
|  |  |  |  |  |  |  |  |  |
| **Service Rendered** |
| **Authorization #: #:** |       |  | **Final:** Billed: | [ ]  Yes [ ]  No |  |
| Clinician: |       |  |
| Client Diagnosis**:** |       |  |
|  |  |  |  |
| **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.