Practice _____

Address _____

City, ZIP _____

Phone _____

SUPERBILL

_____

Date issued _____

PROVIDER

Rendering _____

NPI _____

Tax ID _____

License _____

PATIENT

Name _____

Date of birth _____

Address _____

Phone _____

INSURANCE

Carrier _____

Member ID _____

Group # _____

DIAGNOSIS CODES ICD-10-CM

A _____ _____ **B** _____ _____

C _____ _____ **D** _____ _____

E _____ _____ **F** _____ _____

SERVICES RENDERED CPT / HCPCS

DATE	CPT	MOD	DESCRIPTION	POS	DX	UNITS	FEE	AMOUNT

Place of service: 02 = Telehealth (not in patient home) · 10 = Telehealth in patient home · 11 = Office · 12 = Home

Total charges _____

Amount paid _____

Balance due _____

I certify that the services listed above were rendered to the patient on the dates shown.

PROVIDER SIGNATURE _____ DATE _____

This superbill is a statement of services for the patient to submit to their insurance carrier for reimbursement. It is not a bill from the insurer.