Southeastern Regional Mental Health, Developmental Disabilities and Substance Abuse Services

Monthly Collections Report

Month of _____, 200__

Facility Name: _____Billing Number: _____

Consumer Name	Medicaid/IPRS Number	Procedure/Service Code	Payer (Self-Pay, Insur. Co-Pay, Deductible)	Date Range Paid	Amount Paid
TOTAL					

Report Completed by: _____ Phone Number: _____