WESTERN HIGHLANDS

NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Provider Name & Address	Client ID:	Client Name:	
	Billing Period	Billing Date	Invoice Number	Service Provided

Authorization Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Fee

Signature

Date

* * * T O T A L * * *

KEY: X=Client Present
TL=Ther. Leave