ALABAMA DEPARTMENT OF PUBLIC HEALTH
SOCIAL SERVICE REPORT / MEDICAID BILLING FORM

(For Finance Use Only)

Last Name | F.I. | Month | Year | CHR CO./ Site Code | SOCIAL SECURITY NUMBER

☐ Key for Billing **ONLY**

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Date of Service Mo	Da	NAME OF CONTACTS (PATIENT, AGENCY, ORGANIZATION) FIRST NAME	LAST NAME	NOTES	PATIENT NUMBER (CHR # / SSN OR COUNTY & SITE CODE)	SERV AREA	ACT TYPE	BEG TIME (7:00 am)	END TIME (6:59 pm)	TCM PRIOR AUTHORIZATION # Physician's (10 digit) or Provider (6 digit)

COMMONLY USED SERVICE AREAS					ACTIVITY TYPES
10 - Maternity Case Mgmt 11 - MCM Non-Bill 12 - Health Educ. Classes 13 - Medically at Risk TCM 20 - Family Planning	30 - Child Health 32 - WIC 33 - Newborn Screening CM 36 - Lead Screening CM 40 - HH Direct Service	48 - HH Administration 60 - CD 61 - Non-Bill CD 70 - Adult Health 71 - E/D Waiver CM	80 - Mat. Care/Coord. 81 - Delivery 82 - Intake Only 83 - No Prenatal Visit	90 - General Office 91 - Paid Absence 92 - Training	1 - Recruitment 2 - Face to Face 3 - Client Collateral 4 - Other