

**PAYMENT VOUCHER SUPPORT SHEET
MONTHLY REPORT**

Provider: NAME
ADDRESS
ADDRESS

Contract No.: VL25P

Month and Year

Contact Person: First and Last

Assessment Visits: An ASTERISK (*) shall be placed in the date admitted to indicate Assessment Visits

Name	Date Admitted	Category %	DATES				Individual/Marriage/Family					Group								
			Individual/Marriage/Family	Group	Biofeedback	Medication Review	100%	50%	30%	20%	10%	5%	100%	50%	30%	20%	10%	5%	100%	
		100%																		
		50%																		
		30%																		
		20%																		
		10%																		
		5%																		
SAMPLE																				

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			Individual/Marriage/Family	Group	Biofeedback	Medication Review	100%	50%	30%	20%	10%	5%	100%	50%	30%	20%	10%	5%	100%	
Breakdown of sessions						Individual sessions						Group sessions								
Session Fee						\$150	\$75	\$45	\$30	\$15	\$8	\$80	\$40	\$24	\$16	\$8	\$4	\$100		
Total number of sessions per percentage rate						0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total \$ amount per percentage for reimbursement rate						\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total number of sessions per type of session						0						0								
Total number of sessions						0						Grand Total reimbursement								

SAMPLE

