NorthCare Substance
Abuse Services
Women and Family Quarterly Billing

Program_____
Period Covered_____

Client Name and Social Security Number	Admit Date	Medicaid or BG	Initial Intake Charge	Case Management Charge (3 months) Include Charge & categories that apply (6 ABCDEGHIJ)			Include Receipts Transportation 1 N Childcare 1 M	1 A-O Primary Medical	Misc Billing Category and charge *
Misc. Charges and/or Comments * Please be specific and include itemized receipts									
7A Specialized Materials-Please explain and attach itemized receipts									
TOTAL Charges									
TOTAL ALL Charges									
Please Note: Submission of this Women & Families Billing does not guarantee payment.									

_____
Authorized Signature

_____
Date