EBPT INVOICE

DATE	
PROVIDER NAME *	
PROVIDER NPI *	
CERTIFICATION	☐ DBT ☑ EMDR ☐ TF-CBT
QUARTER	**1** ☐ Jul-Sep **2** ☐ Oct-Dec **3** ☐ Jan-Mar **4** ☑ Apr-Jun

FOR OFFICE USE ONLY	
INVOICE #	
APPROVED TOTAL	

*Reimbursement will be to Provider Name/NPI indicated

TO:
MO HealthNet Division
Attn: Behavioral Health Services Manager
PO Box 6500
Jefferson City, MO 65102-6500

FOR: ENHANCED REIMBURSEMENT OF EVIDENCE-BASED TREATMENT FOR CHILDREN WHO HAVE EXPERIENCED SEVERE TRAUMA

ICN	DATE OF SERVICE MM/DD/YY	PARTICIPANT DCN	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	NUMBER OF UNITS	PAYMENT AMOUNT (UNITS X $10)
							$ 0.00
							$ 0.00
							$ 0.00
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I ATTEST THAT ALL PROCEDURES LISTED ON THIS INVOICE ARE QUALIFYING EVIDENCE-BASED PRACTICES PROVIDED TO INDIVIDUALS MEETING PARTICIPANT CRITERIA IN ACCORDANCE WITH MHD PROVIDER BULLETIN VOLUME 40 NUMBER 48.

$ 0.00

PROVIDER SIGNATURE: _____

SEND INVOICE TO : MHD.BehavioralHealth@dss.mo.gov

Email must be encrypted. Instructions for email encryption may be found at https://dss.mo.gov/encrypt.htm.

REIMBURSEMENT WILL NOT BE MADE WITHOUT RECIEPT OF COMPLETED FORM