

Documentation for Reimbursement

Date _____

Attn: Case Manager

Ins. Company _____

Re: [Name of child or adolescent; dob]

To whom it may concern,

I saw [name of child or adolescent] on [visit date] for [diagnosis].

This letter documents the components of the services provided and billed with the diagnosis code of _____.

The following services were provided:

___ Parent conference regarding the diagnosis, etiology, management, and medical treatments of [diagnosis name]. This conference lasted approximately _____ minutes.

___ Face-to-face visit with child or adolescent for additional discussion and initiation of therapy. This visit lasted approximately _____ minutes.

___ Correspondence to the school [name of child or adolescent] attends.

___ Review of school records.

___ Phone consultation(s). These consultations lasted a total of approximately _____ minutes.

___ Other: _____

Should you have any additional questions or wish these services to be coded in a different way, please contact _____ in my office.

Thank you for your consideration.

Sincerely,

[Name of health professional]