

# DOULA SERVICES SUPERBILL

## PROVIDER INFORMATION

Provider Name: \_\_\_\_\_

Business Name: \_\_\_\_\_

NPI: \_\_\_\_\_

Tax ID / EIN: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## CLIENT INFORMATION

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Insurance Plan: \_\_\_\_\_

Insurance ID: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Issue: \_\_\_\_\_

## SERVICES RENDERED

| Date | CPT Code | Visit Type / Description | Qty | Unit Rate | Total |
|------|----------|--------------------------|-----|-----------|-------|
|      |          |                          |     |           |       |
|      |          |                          |     |           |       |
|      |          |                          |     |           |       |
|      |          |                          |     |           |       |
|      |          |                          |     |           |       |
|      |          |                          |     |           |       |
|      |          |                          |     |           |       |
|      |          |                          |     |           |       |

**TOTAL CHARGES DUE:** \_\_\_\_\_

## CERTIFICATIONS

*I certify that the services listed above were provided to the client identified, and that the information is true and correct to the best of my knowledge.*

Provider Signature: \_\_\_\_\_

\_\_\_\_\_  
*Sign here*

Date: \_\_\_\_\_

*I acknowledge receipt of the services listed above. (Optional)*

Client Signature: \_\_\_\_\_

\_\_\_\_\_  
*Sign here*

Date: \_\_\_\_\_