NON-Medicaid TCM Monthly Billing Form

Date: **Client Name:**

Date of Birth: **Social Security Number:**

TCM:

Provider (Please select one): TECH

Please Attach Case Notes

I acknowledge these funds are made available through a contract between the Service Provider and the CDDO. As such, the amounts and service are subject to change based on availability of funds. This funding plan does not grant entitlement to ongoing services. Funding plans are due to the CDDO by the end of the month following when the service is provided.

Targeted Case Manager:_____ Date:_____

CDDO Use Only

Acct#: 6860-

_____Total Units/Days x $18.75 = $ __ __ __ . __ __

Date Approved: _____

Approved by:_____ _____ *XIX Beneficiary Check*

RE: 6/19/23