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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Developmental Disabilities Administration (DDA)  **Specialized Evaluation and Consultation  Provider Invoice** | | | | | | | |
| Client Name | | | | Date(s) Provided | | | Year | |
| DDA Case Resource Manager | | | | | | | | |
| **Note:** Services must be pre-approved by DDA. | | | | | | | | |
| Service Provided | | Service Code | Code Modifier | | Date(s) Provided | | | Fee |
| Direct Support – Individual | | H2019 | U1 | |  | | |  |
| Direct Support – Group | | H2019 | U3 | |  | | |  |
| Treatment Team Meeting (Attendance) | | H2019 | U2 | |  | | |  |
| Report Development - Paid once per quarter for quarterly report and once per year for annual report - Use Specialized Evaluation and Consultation forms | | SA040 | U1 | |  | | |  |
| **Total** | | | | | |  | | |
| Name of Person Performing the Service | | | | | | Provider Number | | |
| Company / Agency | | | | | | | | |
| Signature | | | | | | Date Sent to DDA Case Manager | | |