STATE OF FLORIDA SUBSTANCE ABUSE & MENTAL HEALTH CLIENT SPECIFIC SERVICE EVENT FORM

(* Mandatory Fields) (Reference: Chapter 7, DCF Pam 155-2)

Client's Name:

1. *CONTRACTOR IDENTIFIER: ___ ___ - ___ ___ ___ ___ ___ ___ ___ Federal Tax Identification number ex. 59-1234567.	Page 7 – 4
2. *SITE IDENTIFIER: ___ ___	Page 7 – 4
3. *CLIENT SSN: ___ ___ - ___ ___ - ___ ___ ___ ___ The SSN must be 9 digits without dashes. It cannot start with 000 or 999. If unavailable use Pseudo-social. Instructions in SAMH Pamphlet	Page 7 – 4
4. CLIENT ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	Page 7 – 4
5. *PROVTYPE: ___ ___ (Type of staff providing service)	Page 7 – 4
6. *SERVICE COUNTY: ___ ___ (Codes listed in Table 6 of Appenix 5)	Page 7 – 4
7. *COVERED SERVICES: ___ ___ (Codes listed in Table 1 of Appenix 5)	Page 7 – 4
8. *FUND: ___ ☐ 2-SAMH ☐ 3-TANF ☐ 5-Local Match Only ☐ B-Title 21	Page 7 – 5
9. *PROGRAM TYPE: ___ ☐ 1-Mental Health ☐ 2-Substance Abuse	Page 7 – 5
10. *PROCEDURE CODE: ___ ___ ___ ___ ___ (Refer to Appendix 1 for codes)	Page 7 – 5
11. *SERVDATE: ___ ___ ___ ___ ___ ___ ___ ___ (Format = YYYYMMDD)	Page 7 – 5
12. *UNIT TYPE: ___ ___ ___ ___	Page 7 – 5
13. *SETTING: ___ ___ (Codes listed in Table 16 of Appenix 5)	Page 7 – 5
14. *BEGIN TIME: ___ ___ ___ ___	Page 7 – 5
15. HEALTH PLAN: ___ ___ ___ ___ ___ (Must be space filled)	Page 7 – 5
16. CLAIM ID: ___ ___ ___ ___ ___ (Must be space filled)	Page 7 – 5
17. STANDARD CHARGE: ___ ___ ___ (Must be space filled)	Page 7 – 6
18. RECIPIENT PAID: ___ ___ ___ (Must be space filled)	Page 7 – 6
19. PAYMENT: ___ ___ ___ **[001]** FULL **[002]** PARTIAL	Page 7 – 6
20. *CONTRACT NUMBER 1: ___ ___ ___ ___ ___	Page 7 – 6
21. *STAFF ID: ___ ___ - ___ ___ ___ ___ ___ ___ ___ ___ ___	Page 7 - 6
22. MODIFIER 1: ___ ___ (Left Justified/Space Filled)	Page 7 – 6
23. Blank: ___ (Must be space filled)	Page 7 – 6

24. MODIFIER 2: ___ ___ (Left Justified/Space Filled)	Page 7 – 6
25. Blank: ___ (Must be space filled)	Page 7 – 6
26. MODIFIER 3: ___ ___ (Left Justified/Space Filled)	Page 7 – 6
27. Blank: ___ (Must be space filled)	Page 7 – 6
28. *MODIFIER 4: ___ ___ (Appendix 2 or 5)	Page 7 – 6
29. Blank: ___ (Must be space filled)	Page 7 – 6
30. PROVIDER INFORMATION: __	Page 7 – 7
31. FUND 2: ___	Page 7 – 7
32. CONTRACT NUMBER 2: ___ ___ ___ ___ ___	Page 7 – 7
33. PROVIDER ID: ___ ___-___ ___ ___ ___ ___ ___ ___ ___	Page 7 – 7
34. SERVICE BILLED AMOUNT: ___ ___ ___ ___ ___.___ ___	Page 7 – 7
35. SERVICE PAID AMOUNT: ___ ___ ___ ___ ___.___ ___	Page 7 – 7
36. TREATMENT BEGIN: ___ ___	Page 7 – 7
37. TREATMENT END: ___ ___	Page 7 – 7
Signature: ____ Date: _____/______/________	