SUPERBILL

For Possible Out-of-Network Reimbursement

Provider Information

Practice Name: _____
Provider Name & Credentials: _____
NPI #: _____
Tax ID (EIN): _____
License #: _____
Address: _____
Phone: _____
Email: _____

Client Information

Client Name: _____
Date of Birth: _____
Client Address: _____
Phone/Email: _____

Service Details

Date of Service	Service Description	CPT Code	Duration	Fee per Session	Amount Paid
				$	$
				$	$
				$	$

Total Amount Paid: $_____

Diagnosis / ICD-10 Codes

Diagnosis Description	ICD-10 Code

Payment Information

□ Paid by Client
□ Paid in Full
□ Partial Payment
□ Outstanding Balance: $_____

Payment Method: □ Cash □ Credit Card □ Check □ Other: _____

Provider Signature

I certify that the services listed above were provided as described.

Provider Signature: _____
Date: _____

Client Acknowledgment *(optional)*

I confirm that I received the services listed above and understand this superbill may be submitted to my insurance for possible reimbursement.

Client/Guardian Signature: _____
Date: _____

Notes

- This superbill is for **out-of-network reimbursement purposes**.
- Submission of this form does **not guarantee insurance reimbursement**.
- Clients should verify benefits directly with their insurance carrier.