San Bernardino County Department of Behavioral Health

Charge Data Correction Invoice

Date Prepared: _____ Staff Signature: _____ Staff Number: _____

Clinic Name: _____ Reporting Unit _____

Reason for deletion: _____

SERVICES TO BE DELETED

Client Number	Client Name	Service Date	Proc Code	Primary Staff Time	Co-Staff Number	Co-Staff Duration	Group Count	Service Location	EBP /SS	Bus. Ofc. Use Only
										B / P / D
										B / P / D
										B / P / D
										B / P / D
										B / P / D
										B / P / D

SERVICES TO REPLACE DELETIONS

Client Number	Client Name	Service Date	Proc Code	Primary Staff Time	Co-Staff Number	Co-Staff Duration	Group Count	Service Location	EBP /SS	Bus. Ofc. Use Only

Clinic Staff Submitting: _____ Phone: _____ Date: _____

Correction Data Entry by: _____ Phone: _____ Date: _____