

Missouri First Steps Offline Billing Request

Service Coordinator	Child Name	Child ID
Provider Name	Payee Name	

Reason for Offline Billing: _____

Authorization #: _____ **Description:** _____

Service Type: _____ **Frequency:** _____

Date of Service	Place of Service	Local EI Code	CPT	Units	Minutes	Charges per Date of Service
Total Charges:						

Corresponding documentation located in WebSPOE or attached.

I certify the above billed services were provided in accordance with the child's Individualized Family Service Plan.

Provider Signature	Date
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Submit completed request to the Area Director or SPOE Office