

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

CLINIC RECEIPTS TRANSMITTAL

DEPOSIT DATE _____

CONTROL UNIT NUMBER _____

CLINIC NAME _____ STATE PROVIDER NUMBER _____

Enclosed are Departmental Receipts numbered _____ through _____
and:

Check(s)/money orders totaling \$ _____

Cash totaling \$ _____

for a grand total of \$ _____

REVENUE BY CATEGORY:

| | <u>Short-Doyle</u> | <u>Federal Medi-Cal</u> |
|----------------------------|--------------------|-------------------------|
| Client Payments | \$ _____ | |
| Medicare Payments | _____ | |
| Med-cal w/share of Cost | | \$ _____ |
| Insurance Payments | _____ | _____ |
| Other | _____ | |
| Grand Total Collections | \$ _____ | \$ _____ |

Revenue was collected _____ through _____ (dates).

PREPARED BY:

VERIFIED BY:

Signature _____

Title _____

Telephone Number _____

Revised 4/88