

Claim-Support Billing Note Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A **claim-support billing note** ties a billed code to what happened in session: service, time, diagnosis, medical necessity, and an authenticated author. Use it as a pre-claim check, records-request response, or compliant addendum; it never replaces the clinical note.

1 – Client and service identification who, when, where, by whom

Do: record identifiers, date of service, place of service, clinician with credential and NPI.

Pitfall: identification that stops at page one; reviewers expect it on every page.

2 – Code and service description the two must agree

Do: state the code, units, and what you did in plain words that match it.

Pitfall: a code-note mismatch, like an intake code on a routine session.

3 – Time countable minutes, in range

Do: give start and stop times or total face-to-face minutes: 16–37 (90832), 38–52 (90834), 53+ (90837).

Pitfall: "about an hour" supports nothing; under 16 minutes is not reportable.

4 – Diagnosis linkage the record must support the code

Do: name the ICD-10 on the claim and how today's session addressed it.

Pitfall: a diagnosis carried forward for years with no current symptoms behind it.

5 – Medical necessity and plan linkage the chain reviewers read for

Do: state current symptoms or functional impact and the numbered plan goal addressed.

Pitfall: check-box forms alone; CMS calls reimbursement-built templates "often insufficient."

6 – Supervision and co-signature when pre-licensed

Do: add the supervisor's name, credential, and co-signature where required.

Pitfall: assuming one rule; payer, program, and state board each set their own.

7 – Authentication signature, credential, date

Do: sign with credentials and date it; only the author may ever attest to a signature.

Pitfall: an attestation can identify an author; it can never backdate a signature.

8 – Addendum or late entry only when needed

Do: label it, date it, identify the author, give the reason, leave the original intact.

Pitfall: integrity reviewers list "excessive late entries" among signs of falsification.

Before the claim goes out

- ☐ Code matches the service described
- ☐ Time inside the billed code's range
- ☐ Diagnosis supported in today's note
- ☐ Plan goal linked
- ☐ Signed, credentialed, and dated
- ☐ No cloned text from prior notes

Drafting with AI

Give it the session note and the code you intend to bill; ask for the claim-support summary and a gap check.

"Check this note against 90834 and draft a claim-support summary: time in range, F41.1 linkage, plan goal, signature elements: ..."

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

100–300 words
typical length

3–6 min by hand
clinical team estimate

At claim, review, or audit
when it's written

Payers · auditors · your biller
who reads it

Claim-Support Billing Note Template

Copy or print for your practice - Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Client (initials):	DOB:	Date of service:
Place of service:	Clinician and credential:	NPI:
Code(s) billed:	Units:	Modifier(s):

Service description

What was done, in plain words that match the code billed

Time started:	Time stopped:	Total face-to-face minutes:
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Diagnosis linkage

ICD-10 code(s) on the claim, and how today's service addressed the diagnosis

Medical necessity

Current symptoms or functional impact supporting the service today

Treatment plan linkage

Numbered goal or objective this session worked toward

Supervisor and credential, where required:	Co-signature date:
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Addendum, only if needed

Label it, date it, identify the author, state the reason; the original entry stays unchanged

Addendum date:	Addendum author:	Reason for late entry:
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Clinician signature / credentials:	Date signed:
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