SCHOOL BASED CHILD HEALTH SERVICES MEDICAID SERVICE INFORMATION: PART 1

DAS ID _____ **LEA CODE** **SB___**

NAME _____ _____

Student Last Name First Name

SS# _____ **DOB** _____ **GENDER** _____

MEDICAID# _____

DATE OF SERVICE			SERVICE CODE (Sort by code, then by date)	SERVICE UNITS Unit = 1 minute thru 15 minutes
Month	Day	Year		

Evaluations Codes:

26-Assessments, unlisted Evals
56- PT Eval
66- SLH Eval
76-Psychological Eval
86-Psychiatric Eval
96- OT Eval

Treatment Codes:

Services must be in Student's IEP

Ind. – Group	
27 - 28	Audiology
47 - 48	Respiratory Svces
49 Group	Respiratory Svces
57 - 58	Physical Therapy
67 - 68	LSH Therapy (Lang-Speech-Hearing)
87 - 88	Counseling/Psych
97 - 98	Occupational Therapy

Other Codes:

17	Medical Diagnostic and Evals
18	Durable Medical Equipment
19	Diagnostic Lab Services
20	Assistive Technology Assess
29	Optometric/Vision Service
36	81 with Medical Services
77	Nursing – RN/APRN
78	Nursing - LPN
89	Family psychotherapy

Provider Name _____ **Position** _____

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

Provider Signature _____ **Date** _____

Supervising Clinician Name _____ **Position** _____
(For non-licensed providers only)

Supervising Clinician Signature _____ **Date** _____