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 Month	Day	Year	SERVICE CODE (Sort by code, then by date)	SERVICE UNITS (per MSI/CPT Code)

Evaluation Codes:

01 Speech fluency Eval
02 Speech sound production Eval
03 Speech sound production *with* Language comprehension/express
04 Behavioral, qualitative analysis voice
30 PT Eval Low
31 PT Eval Mod
32 PT Eval High
33 OT Eval Low
34 OT Eval Mod
40 OT Eval High
71-Psychological Eval
81-Psychiatric Eval
41-Behavior Assessment

Treatment Codes:

Services must be in Student's IEP/504

Ind. – Group	
22 - 23	Audiology
42 - 43	Respiratory Svces
44 Group	Respiratory Svces
52 - 53	Physical Therapy
62 - 63	LSH Therapy (Lang-Speech-Hearing)
82 - 83	Counseling/Psych
92 - 93	Occupational Therapy
70	Behavior Mod Svce
74	Personal Care Asst Svces

Other Codes:

12	Medical Diagnostic and Evals
13	Durable Medical Equipment
14	Diagnostic Lab Services
15	Assistive Technology Assess
24	Optometric/Vision Service
72	Nursing – RN/APRN
73	Nursing - LPN
84	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** __________