SCHOOL BASED CHILD HEALTH SERVICES MEDICAID SERVICE INFORMATION – PART 1

LEA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medcd ID: \_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Check one:** **[ ]  IEP** **[ ]  504**

**SASID: \_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STUDENT LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STUDENT FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **BILLING CODES – use 5 digit OR 2 digit**

**SPEECH**

**92521 / 06 Speech fluency evaluation**

**92522 / 07 Speech sound production evaluation**

**92523 / 08 Speech evaluation- sound production with language, comprehension, expression**

**92524 / 09 Behavioral, qualitative analysis voice evaluation**

**V5299 / 28 Audiology**

**92507 / 67 Speech Therapy Individual**

**92508 / 68 Speech Therapy Group**

**COUNSELING**

**96130 / 55 Psychological Testing 1st hour**

**96131 / 65 Psychological Testing add’l hours**

**90791 / 86 Psychiatric Diagnostic Interview, assessment**

**90832 / 87 Counseling – Individual**

**90853 / 88 Counseling – Group**

**OT/PT**

**97165 / 38 OT Eval Low**

**97166 / 39 OT Eval Mod**

**97167 / 45 OT Eval High**

**97161 / 35 PT Eval Low**

**97162 / 36 PT Eval Mod**

**97163 / 37 PT Eval High**

**97110 / 97 OT – Individual**

**97150 / 98 OT - Group**

**97110 / 57 PT – Individual**

**97150 / 58 PT – Group**

**NURSING**

**T1002 / 77 Nursing – RN/APRN**

**T1003 / 78 Nursing – LPN**

**T1019 / 79 Personal Care Assistant Services**

**OTHER**

**97755 / 20 Assistive Technology Assessment**

**H2014 / 75 Behavior Modification Services**

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| --- | --- | --- |
| **DATE OF SERVICE****MM/DD/YY** | **SERVICE CODE** **(only one code per line)**  | **SERVICE** **MINUTES** |
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Provider Name: (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that the above 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.

Supervising Clinician Name/Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Supervisor signature is required for COTA, PTA, SLPA, BCaBA, and Behavior Techs)**