

SCHOOL BASED CHILD HEALTH SERVICES MEDICAID SERVICE INFORMATION: PART 1

DAS ID **LEA CODE**

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		

Evaluation Codes:

01 Speech fluency Eval
 02 Speech sound production Eval
 03 Speech sound production *with* Language comprehension/express
 04 Behavioral, qualitative analysis voice
 21-Assessments, unlisted Evals
 51- PT Eval
 71-Psychological Eval
 81-Psychiatric Eval
 91- OT Eval

Treatment Codes:

Services must be in Student's IEP

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

Other Codes:

12 Medical Diagnostic and Evals
 13 Durable Medical Equipment
 14 Diagnostic Lab Services
 15 Assistive Technology Assess
 24 Optometric/Vision Service
 31 **81 with Medical Services**
 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** _____