Medicaid Billing & Service Documentation Form

Student Name: _____

Date of Birth: _____

School District Name: _____

Service Period, Year: _____

Services Provided: ☐ OT ☐ PT ☐ ST ☐ PSY ☐ Nursing ☐ Other _____

Date	Activity/Procedure Notes	Billing Codes	Service Time
		Select Billing Code	
		Select Billing Code	
		Select Billing Code	
		Select Billing Code	
		Select Billing Code	
		Select Billing Code	
		Select Billing Code	
		Select Billing Code	
		Select Billing Code	
		Select Billing Code	
		Select Billing Code	
		Select Billing Code	
		Select Billing Code	

X _____ _____

Provider's signature Title Date

X _____ _____

Supervising professional's signature Title Date

(required for services provided "under the direction of")

NRC V1