**SCHOOL BASED CHILD HEALTH SERVICES MEDICAID SERVICE INFORMATION: PART 1**

**Out of District**

**DAS ID LEA CODE**

**NAME**

**SB**

**Student Last Name First Name**

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

**MEDICAID#**

**OOD Evaluation Codes:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DATE OF SERVICE**  **Month Day Year** | | | **SERVICE CODE**  **(Sort by code, then**  **by date)** | **SERVICE UNITS (per MSI/CPT Code)** |
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**06 Speech fluency Eval**

**07 Speech sound production Eval**

**08 Speech sound production *with***

**Language comprehension/express**

**09 Behavioral, qualitative analysis voice**

**35 PT Eval Low**

**36 PT Eval Mod**

**37 PT Eval High**

**38 OT Eval Low**

**39 OT Eval Mod**

**45 OT Eval High**

**55-Psychological Eval 1st hour**

**65-Psychological Eval add’l hours**

**86-Psychiatric Eval**

**46-Behavior Assessment**

**Treatment Codes:**

**Services must be in Student’s IEP/504**

**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**

**75 Behavior Mod Svces**

**79 Personal Care Asst Svces**

**Other Codes:**

**17 Medical Diagnostic and Evals**

**18 Durable Medical Equipment**

**19 Diagnostic Lab Services**

**20 Assistive Technology Assess**

**29 Optometric/Vision Service**

**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**

Revised 11/29/18