MEDICAID SERVICE LOG

School District: Select From Dropdown **Month:**

Last Name: _____ **First Name:** _____

Birth Date: _____ **Medicaid ID#** _____

Service Provider: _____ **Credentials:** _____

Resident District: _____ **Attending School:** _____

Please Check One

Nurse Consult ☐ **OT** ☐ **PT** ☐ **K-12 Speech** ☐ **Aug./Comm.** ☐

Date of Service: _____ **ICD 10 Code:** _____ **Procedure Code:** _____ **Initials:** _____

Minutes: _____ **Student Count:** _____ **Student Present:** **Y** ☐ **N** ☐ **Initials:** _____

Description of Service:

Date of Service: _____ **ICD 10 Code:** _____ **Procedure Code:** _____ **Initials:** _____

Minutes: _____ **Student Count:** _____ **Student Present:** **Y** ☐ **N** ☐ **Initials:** _____

Description of Service:

Multiple Page Form. Signature Page Must Be Attached

Date of Service: _____ **ICD 10 Code:** _____ **Procedure Code:** _____ **Initials:** _____

Minutes: _____ **Student Count:** _____ **Student Present:** **Y** ☐ **N** ☐ **Initials:** _____

Description of Service:

Date of Service: _____ **ICD 10 Code:** _____ **Procedure Code:** _____ **Initials:** _____

Minutes: _____ **Student Count:** _____ **Student Present:** **Y** ☐ **N** ☐ **Initials:** _____

Description of Service:

Provider Signature	**Printed Name/Credentials**	**Date**
Provider Signature	**Printed Name/Credentials**	**Date**

Multiple Page Form. Signature Page Must Be Attached