## Service Record – School Based Audiological Services Billing Form

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| --- | --- | --- |
| **Medicaid Number** | **Last Name** | **First Name** |
|  |  |  |
| **WVEIS Number** | **Date of Birth** | **Provider Name** |
|  |  |  |
| **County** | **School** | **Month/Year** |
|  |  |  |

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| **LIST ALL DIAGNOSIS CODES RELATED TO AUDIOLOGY** |
| **1.** | **2.** | **3.** | **4.** | **5.** | **6.** |

Audiological Therapy Services: Physician’s authorization on file. Services must be identified on the Plan of Care.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Service Date** | **List Diagnosis Code Number(s)** | **Procedure code** | **Start Time** | **End Time** | **Units/Event** |
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  *Signature/Credentials Date Page\_\_\_of\_\_\_*