## Service Record – School Based Occupational Therapy Billing Form

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **LIST ALL DIAGNOSIS CODES RELATED TO OCCUPATIONAL THERAPY** | | | | | |
| **1.** | **2.** | **3.** | **4.** | **5.** | **6.** |

Occupational 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** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature/Credentials Date*

*Page\_\_\_of\_\_\_*

*Co-Signature/Credential Date*

*(Initial dates directly supervised)*