

SUFFOLK COUNTY PRESCHOOL SPECIAL EDUCATION PROGRAM

MONTHLY MEDICAID BILLING REPORT – School Year 2012-2013

Ordering/Referring Provider NPI # _____

Month _____ Year _____

ICD9 Code: _____

Confirm you have In-house: IEP ____ REC / RX ____ LOG NOTES: ____ USO / UDO Forms ____ P/Consent ____

Student Name: _____ (Last Name/First Name)		DOB: _____	CIN #: _____
Agency or Individual Provider: _____	IEP Period: Start Date _____ End Date _____		
Service Provider Name: _____	Location of Service: _____		
USO / UDO Supervisor: _____	Credentials, License #, NPI # _____		
	Credentials, License #, NPI # _____		

Service Type: Please Check Box <input type="checkbox"/> OT <input type="checkbox"/> PT (CAPTE __Y__N) <input type="checkbox"/> ST <input type="checkbox"/> CO <input type="checkbox"/> NU	As per IEP: Group: Frequency _____ Duration _____ Individual: Frequency _____ Duration _____
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Each date of service must indicate: a) Start/End Time; b) the appropriate CPT code & the # of units provided, (i.e. **92507-1** = one Individual speech session ; **97530-2** = two 15 min individual OT sessions). If you did not provide a service on that date, leave blank. If you provide a Make- Up session on any date, use the code **(MU)** in any box on the row associated with that date.

Day of Month	Start Time	End Time	CPT Code Individual & Units	CPT Code Group & Units	CPT Code Other & Units	Day of Month (Cont'd)	Start Time	End Time	CPT Code Individual & Units	CPT Code Group & Units	CPT Code Other & Units
1						17					
2						18					
3						19					
4						20					
5						21					
6						22					
7						23					
8						24					
9						25					
10						26					
11						27					
12						28					
13						29					
14						30					
15						31					
16											

I hereby certify that information provided on this form is a true and accurate representation of the facts.

Print Name and Signature _____

Date _____

☐ Child did not receive ANY services from July 1, 2012 – June 30, 2013

Suffolk County Preschool Special Special Education Program
Monthly Medicaid Billing Report - School Year 2010-2011

For the month of 7/2012

Please indicate Attached: IEP _____ Rec/RX _____ Log Notes _____ USO/UDO Forms _____ P/Consent _____

Student Name:

DOB:

A

Service SP

Indivi 1 Times per week for 30 minutes

Group

Date

Start Time

End Time

CPT-Indiv

CPT-Group

Disabilities Institute

IEP Period: From 7/9/2012 to 8/17/2012

Service Provider:

USO/UDO Supervisor

Location of Service: Center

7/9/2012	10:00 AM	10:30 AM	92507---1 unit(s)
7/16/2012	10:00 AM	10:30 AM	92507---1 unit(s)
7/23/2012	10:00 AM	10:30 AM	92507---1 unit(s)
7/30/2012	10:00 AM	10:30 AM	92507---1 unit(s)

I hereby certify that information provided on this form is a true and accurate representation of the facts.

Date:

Service Provider

Speech Pathologist

Title

License

UDO/Supv

License

☐ Child did not receive ANY services from July1, 2011 - June 30, 2012