

PLEASE PRINT **MEDICAID - DIRECT SERVICE CLAIMS  
RN/LPN LOGS**

**SCHOOL DISTRICT:** \_\_\_\_\_ **PROVIDER NAME:** \_\_\_\_\_

**STUDENT NAME:** \_\_\_\_\_ **PROVIDER TYPE:** \_\_\_\_\_

**AHCCCS ID:** \_\_\_\_\_ **PROVIDER ID #:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**Diagnosis Code or SPED Category:** \_\_\_\_\_ **NURSING CODES: RN - T1002 / LPN - T1003  
(15 Minutes per unit.)**

**Circle Appropriate Month:** → July Aug Sept Oct Nov Dec Jan Feb Mar Apr May June

DATE	UNITS	SERVICE CODE	COMMENTS
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**Nursing Services:** Administering Medication, Suctioning, G-Tube Feeding  
Ventilator Care, Catheter Care, Seizure Control

I certify that the services indicated above were performed by me and are indicated in the IEP.  
**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_