

PLEASE PRINT

Medicaid-Direct Service Claims Psychiatrist Service Log

SCHOOL DISTRICT: _____

PROVIDER NAME: _____

STUDENT NAME: _____

PROVIDER #: _____

AHCCCS ID: _____

PROVIDER TYPE: _____

Diagnosis Code or SPED Category: _____

Provider Phone #: _____

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

Day	UNITS	SERVICE CODE	COMMENTS
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PSYCHIATRIST: 90501 Psychiatric diagnostic interview examination
90802 Interactive psychiatric diagnostic interview examination

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