

PLEASE PRINT

Medicaid Direct Service Claims

School Based Licensed School Psychologist

Provider Type 89

SCHOOL DISTRICT: _____

PROVIDER NAME: _____

STUDENT NAME: _____

PROVIDER ID: _____

AHCCCS ID: _____

Diagnosis Code or SPED Category: _____

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

Day	Units	Service Code	Comments
1			
2			
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Code	Description	
H0031	Comprehensive multidisciplinary evaluation, initial or re-evaluation	30 min units
H0004	Individual Therapy/Counseling	15 min units
H0004-HR	Family Therapy/Counseling with student present	15 min units
H0004-HS	Family Therapy/Counseling without student present	15 min units
H0004-HQ	Group Therapy/counseling	15 min units

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

SIGNATURE: _____

DATE: _____