2017-18
Aurora Public Schools District 28J

Aurora Public Schools
MEDICAID DEPARTMENT

Required fields are noted with an asterisk (*)

AUDIOLOGY SERVICES

(Please use Diagnostic Log for Evaluations)

Provider Type (Check One)

__SLP* _X_Audiologist*
__Psych/SW/Counselor __Nurse (RN)
__OT/PT
__Other(specify)_____

Service Categories
I = Individual G = Group

*Service Date	*Student ID	*Student's Name & DOB	School & Description/Comments on Service Provided	*ICD 10 Code	*Service Category (Circle one)	*Actual Minutes	*Provider Initials
					I G		
					I G		
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I certify that the information provided on this form is true and accurate and that the services were provided in accordance with federal and state laws applicable to Medicaid.

***Provider's Signature_____ *Initials_____ *End of Month Date_____**

***Provider's Printed Name_____**