2017-18
Aurora Public Schools District 28J

Aurora Public Schools
MEDICAID DEPARTMENT

Required fields are noted with an asterisk (*)

DIAGNOSTIC SERVICES

Provider Type (Check One)

__**SLP***
__**Audiologist***
__**Psych/SW/Counselor**
__**Nurse (RN)**
__**OT/PT**
__**Other(specify)**_____

Service Categories
2a Initial Evaluation **2b Re-Evaluation**

***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**
					2a 2b		
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					2a 2b		

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**_____