Colorado School Medicaid Consortium ©
ICD-10_____

Aurora Public Schools
MEDICAID DEPARTMENT

DIAGNOSTIC SERVICES
For *Child Find*

Provider Type (Check One)
__SLP* __Audiologist*
__Psych/SW/Counselor __Nurse (RN)
__OT/PT
__Other(specify)_____

Service Categories
2a Initial Evaluation 2b Re-Evaluation

Date	Student ID	DOB	Student's Name	Description/Comments on Service Provided	Service Category (Circle one)	Actual Minutes	Provider Initials
					2a 2b		
					2a 2b		
					2a 2b		
					2a 2b		
					2a 2b		
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					2a 2b		
					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_____ Date_____

***Supervisory Signature_____ Initials_____ Date_____**
(Supervisory signature needed for: SLP's in their CFY or with only CDE licensure; and for Audiology candidates in their CFY)