Medicaid Number:_____

Medicaid Verification

Student Name: _____ Teacher of Record:_____

❏ 1. Does the student have billable services? : ☐Yes ☐ No (If yes go to #2, if no stop here)

❏ 2. What are the billable services:

- ❏ Audiology Service _____
- ❏ Braille Support Service
- ❏ Interpreting Services
- ❏ Occupational Therapy _____
- ❏ Personal Care Services
  - ❏ Please provide all information to the aide/aides working with this student.
- ❏ Physical Therapy _____
- ❏ Psychological Services
- ❏ School Nursing Services
- ❏ Sign Language Support Services
- ❏ Speech-Language Therapy_____
- ❏ Transportation Services
- ❏ Behavior Intervention Plan_____
- ❏ Health Care Plan_____

☐ 3. Did you receive a signed consent to bill for Medicaid?:

☐ Yes, Parent agreed_____ (date continue to #4) ☐ Yes, Parent Denied/Incomplete form_____ date (stop here)

☐No: Date of Attempt to Receive Consent (You must attempt 3 times): 1st_____ 2nd_____3rd_____

☐ 4.Physician ☐Authorization / Script Attempt: 1st_____2nd_____ 3rd_____

Coordinate with Related Service Provider:_____

☐ 5. Is there a service care plan signed: ☐Yes ☐ No

- ❏ Date Received : _____
- ❏ Date of Attempt to Receive Signed Plan: 1st_____ 2nd _____ 3rd_____