LEA Medicaid Billing - Service Documentation – Health Paraprofessional

Student name: _____ Birthdate: _____ ICD 9 code(s): _____ (primary)
School district: _____ Building: _____ _____

Services:

Date of Service	Time in	Time out	Total time (minutes)	Service code (see below)	Procedure/ intervention (describe if no code below)	Comments / Student response	Medical supplies - type & quantity	Initials

Total time _____ (minutes) (Procedure code T1019 - 15 min. unit)
(Procedure code T1020 – per diem)

Total cost - Medical supplies _____ _____
(Procedure code T1999 - $25 max/month)

Nursing specific services:		**Non-Nursing specific services:**		
Blood sugar check = BS	Metered-dose inhaler = MDI	Assist with ambulation = AA	Oral feeding = OF	Position/ transfer to side lyer = PSL
Catheterization = CA	Nebulizer treatment = NT	Assist in wheelchair = AW	Oral stimulation exercises = OSE	Range of motion exercises = ROM
Chest percussion = CP	Oral suction = OS	Assist on/ off bus = AB	Personal hygiene = PH	Toileting = T
Gastrostomy tube feeding = TF	Oxygen therapy = O2	Diaper/ brief change = DC	Position/ transfer to chair = PC	Other Health Monitoring = OHM
Medication admin. = MA	Seizure monitoring = SM	Lunch setup = LSU	Position/ transfer to stander = PS	

Service providers:

Signature	Initials	Position	Signature*	Initials	Position: Health prof. (below)
Signature	Initials	Position	**Circle one:** School Nurse	PT	OT SLP

* I attest that the services/ interventions provided by the LEA staff members are consistent with this student's treatment plan or specific goal(s) as described in the student's IEP. This does not imply my supervision of the LEA staff members, nor have I necessarily observed these services.

(7-6-04)