S.K.A.C.D. #613 Medicaid Billing Log

Office Use Only
Medicaid#_____

Student:	DOB:	Gender: M F
	Diagnosis: 783.40	
Service Provider:	Location of Services	

Date	Time In	Time Out	Treatment and Response	Initials	Charge Per Unit	Sub Total

Type of Service OT,PT,SL,AC,SH
Procedure Code
# of Units

Goal Progress
__ 4-Task Mastered
__ 3-Significant Progress
__ 2-Adequate Progress
__ 1-Minimal Progress
__ 0-No Improvement

Date	Time In	Time Out	Treatment and Response	Initials	Charge Per Unit	Sub Total

Type of Service OT,PT,SL,AC,SH
Procedure Code
# of Units

Goal Progress
__ 4-Task Mastered
__ 3-Significant Progress
__ 2-Adequate Progress
__ 1-Minimal Progress
__ 0-No Improvement

Date	Time In	Time Out	Treatment and Response	Initials	Charge Per Unit	Sub Total

Type of Service OT,PT,SL,AC,SH
Procedure Code
# of Units

Goal Progress
__ 4-Task Mastered
__ 3-Significant Progress
__ 2- Adequate Progress
__ 1-Minimal Progress
__ 0-No Improvement

Date	Time In	Time Out	Treatment and Response	Initials	Charge Per Unit	Sub Total

Type of Service OT,PT,SL,AC,SH
Procedure Code
# of Units

Goal Progress
__ 4-Task Mastered
__ 3-Significant Progress
__ 2-Adequate Progress
__ 1-Minimal Progress
__ 0-No Improvement

Date	Time In	Time Out	Treatment and Response	Initials	Charge Per Unit	Sub Total

Type of Service OT,PT,SL,AC,SH
Procedure Code
# of Units

Goal Progress
__ 4-Task Mastered
__ 3-Significant Progress
__ 2-Adequate Progress
__ 1-Minimal Progress
__ 0-No Improvement

Please mail to SKACD 613, Attn: Esther, 001 Ford St, Ensign, KS 67841 at the end of the current month.

Signature and Credentials_____**Date**_____