Month_____ Year___

Page______ of_____

ALBUQUERQUE PUBLIC SCHOOLS #E7599
Medicaid School Based Services
Daily Billing Form - Nursing Direct Services (GO154 TM)

Student Name:_______________________________________DOB:___________________School (Place of Service):__________________________________

Student ID Number:__________________________________ IEP Time:_________per____________Physician/ARNP/PA:_____________________________

RN/LPN Review (Signature, Credential/Title):______________________________Print Name:_________________________Date:________________________

Date	Time	Exception Code	ICD-9 Code(s)	Minutes of Service	Description of Service (s) Assessment/Monitoring/Procedures/Other			Student's Reaction to Service	Daily Initial
		☐ Absent ☐ Refused ☐ Field trip ☐ Other			☐ G-tube formula/H20 ☐ Urinary Cath. ☐ Toileting ☐ Suctioning ☐ Trach/Vent Care	☐ Peak Flow ☐ Nebulizer ☐ Glucose/Ketones ☐ Re-Evaluation ☐ Emergency Care: ____________________	☐ Diabetes Management/Education ☐ Asthma Management/Education ☐ Education:__________________ ☐ Assessment: ________________ ☐Other: _______________________	☐ Appropriate ☐ Adverse (see notes)	
		☐ Absent ☐ Refused ☐ Field trip ☐ Other			☐ G-tube formula/H20 ☐ Urinary Cath. ☐ Toileting ☐ Suctioning ☐ Trach/Vent Care	☐ Peak Flow ☐ Nebulizer ☐ Glucose/Ketones ☐ Re-Evaluation ☐ Emergency Care: ____________________	☐ Diabetes Management/Education ☐ Asthma Management/Education ☐ Education:__________________ ☐ Assessment: ________________ ☐Other: _______________________	☐ Appropriate ☐ Adverse (see notes)	
		☐ Absent ☐ Refused ☐ Field trip ☐ Other			☐ G-tube formula/H20 ☐ Urinary Cath. ☐ Toileting ☐ Suctioning ☐ Trach/Vent Care	☐ Peak Flow ☐ Nebulizer ☐ Glucose/Ketones ☐ Re-Evaluation ☐ Emergency Care: ____________________	☐ Diabetes Management/Education ☐ Asthma Management/Education ☐ Education:__________________ ☐ Assessment: ________________ ☐Other: _______________________	☐ Appropriate ☐ Adverse (see notes)	
		☐ Absent ☐ Refused ☐ Field trip ☐ Other			☐ G-tube formula/H20 ☐ Urinary Cath. ☐ Toileting ☐ Suctioning ☐ Trach/Vent Care	☐ Peak Flow ☐ Nebulizer ☐ Glucose/Ketones ☐ Re-Evaluation ☐ Emergency Care: ____________________	☐ Diabetes Management/Education ☐ Asthma Management/Education ☐ Education___________________ ☐ Assessment: ________________ ☐Other: _______________________	☐ Appropriate ☐ Adverse (see notes)	
		☐ Absent ☐ Refused ☐ Field trip ☐ Other			☐ G-tube formula/H20 ☐ Urinary Cath. ☐ Toileting ☐ Suctioning ☐ Trach/Vent Care	☐ Peak Flow ☐ Nebulizer ☐ Glucose/Ketones ☐ Re-Evaluation ☐ Emergency Care: ____________________	☐ Diabetes Management/Education ☐ Asthma Management/Education ☐ Education:__________________ ☐ Assessment: ________________ ☐Other: _______________________	☐ Appropriate ☐ Adverse (see notes)	

Initials=_____Signature and Credentials:_________________________Date:__________ Initials=_____Signature and Credentials:_____________________Date:__________

Printed Name: _______________________________________ Printed Name: _______________________________________

Initials=_____Signature and Credentials:_________________________Date:__________ Initials=_____Signature and Credentials:_____________________Date:__________

Printed Name: _______________________________________ Printed Name: _______________________________________

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Page_____ of_____

Additional Documentation/Date/Signature: