

**PINELLAS COUNTY SCHOOLS
ESE MEDICAID BILLING FORM
MEDICATIONS**



Parent Authorization on Clinic Card

STUDENT NAME _____, _____ DOB: _____
Last First

MEDICAID ID#: _____ STUDENT ID#: _____

DIAGNOSIS: _____ DIAGNOSIS CODE: _____ SCHOOL: _____

Need for nursing services is stated in the IEP/FSP and an RN has signed the IEP or Documentation of Need (PCS # 2-2764). _____ RN _____
Signature Date

DIRECTIONS: Please indicate student's receipt of services with the following time and procedure codes in the appropriate date box below.

PROCEDURE CODE:

(A) T1002KO – Medication Administration RN

(B) T1003KO – Medication Administration LPN

(C) T1004KO – Medication Administration SHA (CNA)

X= Absent

Holiday

Weekend

IEP Date _____

Month/Year		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Total # Daily Doses	# of Doses																															
	Code																															
	Initials																															

Month/Year		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Total # Daily Doses	# of Doses																															
	Code																															
	Initials																															

Nurse's Name: _____ Nurse's Signature: _____ Initials: _____ Date: _____

Nurse's Name: _____ Nurse's Signature: _____ Initials: _____ Date: _____

Nurse's Name: _____ Nurse's Signature: _____ Initials: _____ Date: _____

Nurse's Name: _____ Nurse's Signature: _____ Initials: _____ Date: _____

Nursing Assistant's Name: _____ Nurse's Assistant's Signature: _____ Initials: _____ Date: _____