Minnesota Department of Human Services

IEP/IFSP Services Documentation Log

STUDENT'S NAME	DATE OF BIRTH	ICD-10-CM CODE*	SCHOOL NAME

*ICD-10-CM Code – Informational only – not required on this form. ICD-10-CM must be reported on claim. Verify procedures codes, modifiers and units chart to ensure proper and correct billing.

TYPE OF SERVICE PROVIDED (SERVICE CODE) – check one

O Physical Therapy (T1018-U1) O Mental Health (T1018-U4) O Occupational Therapy (T1018-U2)

O Nursing Services (T1018-U5) O Speech-language Pathology (T1018-U3)

Staff Initials	*Telemedicine services were deemed appropriate for this student. The session was provided using district approved HIPPA compliant software.

Date of Service MM/DD/YYYY	**Start/End Time (must use am/pm) Providing Service**	**Total Minutes Spent Providing Service**	**Number of Children in Group**	**Mode of Service**	**Originating Site (Child)**	**Distant Site (Provider)**	**Description of Services** Enter a description of the actual services provided relating to goals/objectives on the IEP/IFSP, including: activities, results, response, progress, and plan for next session. Please use black pen. Use as many lines as necessary to complete documentation. Do not use pencil, white-out, ditto marks, or arrows.
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Total time for all services: _______

It is a federal crime to provide false information on service billings for Medical Assistance payments. Your signature verifies the time and services entered are accurate and that the services were performed as specified in the child's care plan.

SERVICE PROVIDER NAME (Type or print)	**TITLE**	**SIGNATURE**