Massachusetts School-Based Medicaid (SBMP) Billing Service Documentation for Day/Residential Special Education Schools

Please use this form per Administrative Advisory 2019-3: Updated State Mandated Form for Documentation of Medicaid Service Delivery in Out-of-District Programs (28M/12). This form should only be completed if services meet all requirements for Medicaid reimbursement. In order to be reimbursable, the service must be provided by a qualified practitioner, clinically appropriate and medically necessary, and authorized or ordered by a qualified practitioner when appropriate. Please see the SBMP Interim Claiming Guide[1*] for information about these requirements. The supporting documentation (e.g., authorization and service notes demonstrating medical necessity) may be included with this form or kept in the student's health record.

PART I - Information to be provided by an approved special education day or residential school or educational collaborative
Additional service dates may be included on additional pages.

Student Name					SASID	
Service Date	Procedure Code	Activity/Procedure Notes[2]	Diagnosis Code	Individual or Group (check one)	IEP related service (check one)	Start and End Times
				I __ G __	Yes__ No __	_____ / _____
				I __ G __	Yes__ No __	_____ / _____
				I __ G __	Yes__ No __	_____ / _____

PART II - Signatures to be provided by an approved special education day or residential school or educational collaborative. Please note supervisor must be the same for all services noted on this form (and any additional attached pages). Please fill out one service documentation form (this form) per supervising professional signature needed.

Provider's Signature _____ Date _____

Provider's Name *(please print)* _____ Title _____

Supervising Professional's Signature *(when required for services provided "under the direction of")* _____ Date _____

Supervising Professional's Name *(please print)* _____ Title _____

Name of Approved Special Education School or Educational Collaborative *(please print)* _____

PART III - Information to be provided by Public School District (LEA)

School District Name		Provider Number
Student's MassHealth ID	Student Date of Birth	Service Period, Year

[1] https://www.mass.gov/info-details/sbmp-resource-center#direct-service-claiming-resources

[2] Use the clinically appropriate procedure code from the SBMP Resource Center's SBMP Billable Procedure Codes (https://www.mass.gov/info-details/sbmp-resource-center#direct-service-claiming-resources-).

PART I CONTINUED - Information to be provided by an approved special education day or residential school or educational collaborative
Additional services for the same student are noted below. Please write the student's name and SASID again.

Student Name	SASID

Service Date	Procedure Code	Activity/Procedure Notes[3]	Diagnosis Code	Individual or Group (check one)	IEP related service (check one)	Start and End Times
				I __ G __	Yes__ No __	______ / ______
				I __ G __	Yes__ No __	______ / ______
				I __ G __	Yes__ No __	______ / ______
				I __ G __	Yes__ No __	______ / ______
				I __ G __	Yes__ No __	______ / ______
				I __ G __	Yes__ No __	______ / ______
				I __ G __	Yes__ No __	______ / ______
				I __ G __	Yes__ No __	______ / ______
				I __ G __	Yes__ No __	______ / ______
				I __ G __	Yes__ No __	______ / ______
				I __ G __	Yes__ No __	______ / ______
				I __ G __	Yes__ No __	______ / ______
				I __ G __	Yes__ No __	______ / ______

[3] Use the clinically appropriate procedure code from the "SBMP Billable Procedure Codes" document published on the SBMP Resource Center at https://www.mass.gov/info-details/sbmp-resource-center#direct-service-claiming-resources-.