ORANGE COUNTY DEPARTMENT OF HEALTH PRESCHOOL SPECIAL EDUCATION RELATED SERVICE ATTENDANCE & BILLING FORM

PROVIDE	R NAME: AGENO	CY/INDIVIDUAL						
CHILD'S	NAME			DATE OF BIRTH://				
TYPE OF SERVICE FREQUENCY & DURAT			ATION PER IEP_	TON PER IEP ICD-9 CODE				
SERVICE	MONTH/YEAR _	/ LOCA	ATION OF SERVIC	E				
	·				•			
CPT CODE	RELATION TO CHILD	AUTHORIZED SIGNATURE	SERVICE DATE	TIME (START)	TIME (END)	REASON MISSED**	AMOUNT*	
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		rovider Signature —The s above are the actual dat				t Total*		
	-	t and Total should be added a			J ·			
		also be listed in this colum						
		ent Cancel T-Therapist Cancel, D- No show		wed by one of the following (except Holidays): H-Holiday L-Vacation				
B-Visit Shortened E-Impassable Roads/Weather				I-Conflicting Obligation M-Winter/Spring Recess per Calendar				
		-Attendance at MD, Hosp, Clin G-Iliness or Death in Family	ic J-Religious Obse K- Meeting/Trai		school/Dayca	re Closed		
PROVIDER SIGNATURE				DATE				
		GISTRATION EXP. DATE						
(Requi	ed for CFY, TSHE	ION OF I, PTA, and COTA) GISTRATION EXP. DATE		 .		•		