Westchester County Department of Health
Children with Special Needs

## **CL-2R FORM**

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Page		)TC	

Invoice Number:	Type of Se	rvice:	ICI	O 9 Code	CPT Code		
CONTRACT NAME:	Type of License/Certification:						
Therapist's Name:	herapist's Name: License#/Certification#/Designation:						
Child's Name:				DOB: _	<u> </u>		
IEP- Frequency/duration/method (	IEP Perio	od: From	To				
Name of Other Preschool Children in Group (if applicable)					Date of Birth		
Name & Address of Service Delivery Site:	Service Date	Start Time	End Time	Attendance Code	Caregiver's Initials	Amount Billed	
Attendance Codes:							
Scheduled Session - Specify duration (30 min, 45 min., etc) Example: SS/30SS						3	
Session Cancelled By TherapistTC							
Session Cancelled By FamilyFC							
(Parent signature is required)							
CoordinationCoord							
MakeupM							
	TOTAL # OF SESSIONS:  Total Title Total Title Total Title Ti				his Page \$ Total \$		
To the best of my knowledge, services we	ere provided on the	dates and times	specified above	<del>)</del> .			
Mainstream Program Signature:			Title:		Date:		
Parent/Caregiver Signature (home/facility	· —————					4	
I,Signature of therapist**	do hereby att	est that I am a N	IYS Licensed/Co	ertified	**Title(s)		
and did provide the service as noted on the **Speech-Language Pathologists providing	nis billing form.	de their TSSI D a	artification inform	NPI#:	ıst indicate Sneci	al Education	
Teacher designation. Both TSSLD and TSF  (therapist/agency initials) A	H must have docume	entation on file w	ith their agency.	h*			
appropriate school district.  If the service was provided by a TSHH, C sign the following: I, have provided the "u	OTA or PTA, LPN, I	_MSW, the thera	pist providing "	ınder the directi	on of or supervis		
Print Name Signature of Licens			/Certification#/De		NPI# ASH	A #	

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