**Massachusetts School-Based Medicaid (SBMP) Billing Service Documentation**

**for Day/Residential Special Education Schools**

Please use this form per [Administrative Advisory 2019-3](http://www.doe.mass.edu/sped/advisories/2019-3.html): 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](https://www.mass.gov/info-details/sbmp-resource-center#direct-service-claiming-resources)[[1]](#footnote-1)[[2]](#endnote-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.

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| **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[[3]](#footnote-2) | Diagnosis | 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)*

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

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| **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[[4]](#footnote-3) | Diagnosis | 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 \_\_ | **\_\_\_\_\_ / \_\_\_\_\_** |

1. https://www.mass.gov/info-details/sbmp-resource-center#direct-service-claiming-resources [↑](#footnote-ref-1)
2. [↑](#endnote-ref-1)
3. 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-) ([https://www.mass.gov/info-details/sbmp-resource-center#direct-service-claiming-resources-](https://www.mass.gov/info-details/sbmp-resource-center%23direct-service-claiming-resources-)). [↑](#footnote-ref-2)
4. 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-. [↑](#footnote-ref-3)