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| *North Carolina Infant-Toddler Program* |  |

*Provider Service Note and Billing Ticket*

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| Name of ITP Provider Agency: | | | | | | | |  | | | | | | | ITP Provider’s Name: | |  | | | | | |
| Provider Vendor Number: | | | | | |  | | | Provider Discipline: | | | |  | | | | | | | | | |
| V-Code Assignment [PT/OT/SLT]: | | | | | | | | |  | | Service Order Date [if applicable]: | | | | |  | | | Scheduled Frequency: | | |  |
| Child’s Name: | | | |  | | | | | | | | | Child’s Medicaid ID Number: | | | | | | | |  | |
| Child’s Date of Birth: | | | | |  | | | | | | | | Name of Service Coordinator: | | | | | | |  | | |
| IFSP Outcomes Utilized: [Indicate IFSP Goal/Outcome number and brief description beside each.] | | | | | | | | | | | | | | | | | | | | | | |
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| **Legend for Place of Service [POS]: Home or other community setting = 12 Office = 11 Health Dept. = 71 Rural Health Dept. = 72 [See DMA website for additional codes.]** *NOTE: Each encounter must include [1] date of service, [2] purpose of contact, [3] description of provider’s interventions, and [4] the effectiveness of the interventions, including achievements or measurable progress. The duration of the service [in minutes] must also be included in each service note.* | | | | | | | | | | | | | | | | | | | | | | |
| Svc Date: | | |  | | |  | | | | | | | | | | | | | | | | |
| Goal #(s): | | |  | | |  | | | | | | | | | | | | | | | | |
| Proc. Code: | | |  | | |  | | | | | | | | | | | | | | | | |
| # Units: | | |  | | |  | | | | | | | | | | | | | | | | |
| # Minutes: | | |  | | |  | | | | | | | | | | | | | | | | |
| DIAG. | | |  | | |  | | | | | | | | | | | | | | | | |
| POS | | |  | | |  | | | | | | | | | | | | | | | | |
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|  | | |  | | | Signature & Title: | | | | | | | | | | | | Date of Signature: | | | | |