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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.] |
| # |       | # |       |
| # |       | # |       |
| # |       | # |       |
| # |       | # |       |
| **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 |       |  |
|  |  |  |
|  |  | Signature & Title:      | Date of Signature:      |