Early Intervention Confirmation of Service Delivery

Mo/Yr_____

Child's Name (Last, First) *DOB:*	*Agency* *NPI #* *MKSA, LLC* *1700208709*	*County*	*Service SP/OT/PT/SPED/ABA/FT/SW* *Frequency* *Duration*
***Print** Name of Service Provider / License or Cert #/NPI #*	I certify that on the dates below, the above-named child received the services noted and that documentation exists and is maintained on file verifying the delivery of said services in accordance with all relevant federal, state and local laws and regulations governing the Medicaid process. **Provider Signature:** _____ **Date:**_____		

Date of Service	Start time	End time	Session Code: P CA TA MU H	Parent/Guardian Signature/Verifying Witness Signature	Provider Signature
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