

Early Intervention Confirmation of Service Delivery

Mo/Yr _____

Child's Name (Last, First)	DOB:	Agency MKSA, LLC	NPI # 1700208709	County	Service SP/OT/PT/SPED/ABA/FT/SW	Frequency	Duration	
<u>Print Name of Service Provider / License or Cert #/NPI #</u>		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
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