**Important Steps, Inc.**

***Early Childhood Program***

# ITINERANT BILLING FORM – MONTHLY

#  *Evaluations –IFSP Attendance*

THERAPIST:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FOR THE MONTH OF:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_202\_\_\_

ST\_\_\_\_ Psych\_\_\_\_ OT\_\_\_\_ PT\_\_\_\_ SW\_\_\_\_ Ed\_\_\_\_ NUTR\_\_\_\_OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s EI# \_\_\_\_\_\_\_\_\_\_\_\_\_ CPT Code: \_\_\_\_\_\_\_\_

Eval\_\_\_ IFSP\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ Amount Due: \_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s EI# \_\_\_\_\_\_\_\_\_\_\_\_\_ CPT Code: \_\_\_\_\_\_\_\_

Eval\_\_\_ IFSP\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ Amount Due: \_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s EI# \_\_\_\_\_\_\_\_\_\_\_\_\_ CPT Code: \_\_\_\_\_\_\_\_

Eval\_\_\_ IFSP\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ Amount Due: \_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s EI# \_\_\_\_\_\_\_\_\_\_\_\_\_ CPT Code: \_\_\_\_\_\_\_\_

Eval\_\_\_ IFSP\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ Amount Due: \_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s EI# \_\_\_\_\_\_\_\_\_\_\_\_\_ CPT Code: \_\_\_\_\_\_\_\_

Eval\_\_\_ IFSP\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ Amount Due: \_\_\_\_\_\_\_\_\_\_\_\_\_

## Total Due for Evaluations: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Total Amount Due for IFSP Attendance (in Person)** $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Discipline** | **CPT Code** | **ICD-10 Code** | **Description** |
| **Psych** | **90791**  | **F84.0/Autism** | **Psychiatric diagnostic interview without medical services** |
| **Speech** | **92523** | **F80.2** **F80.1**  | **Evaluation of Expressive, Receptive language** |
| **Speech - Feeding** | **92610** | **F98.29** | **Evaluation of speech, language, voice, communication, auditory** |
| **SI** | **96112** | **F81.9 / F89** | **Developmental Evaluation (Core or Supplemental Eval)** |
| **SW/RN** | **H1011** | **N/A** | **Family Assessment by licensed health professional for state defined purposes** |
| **PT** | **97163** | **M62.81** | **Physical Therapy Evaluation** |
| **PT** | **97161** | **M62.81** | **Physical Therapy Re-evaluation** |
| **OT** | **97165** | **R27.9** | **Occupational Therapy Evaluation (1 per calendar year)** |
| **OT** | **97166** | **R27.9** | **Occupational Therapy Re-evaluation (1 every 3 months)** |
| **Nutrition** | **97802** | **E63.9** | **Initial assessment (15 minutes per CPT code)** |
| **Nutrition** | **97803** | **E63.9** | **Initial re-assessment (15 minutes per CPT code)** |
| **Vision**  | **99172** | **H53.8** | **Vision Screening** |

**Please use ICD-10 Code: Z13.40 if no eligibility was established.**

**\*\*\*W2 Evaluators: Attach “Consent for Evaluation” –Original for each Eval. Above\*\*\***

***Revised March 2019***