

Reviewed by: \_\_\_\_\_

LITTLE MEADOWS EARLY CHILDHOOD CENTER  
67-25 188<sup>TH</sup> STREET, FRESH MEADOWS, NY 11365

**EI BILLING FOR AT HOME SERVICES**

Child's Name: \_\_\_\_\_

TYPE OF SERVICE: BASIC HOME \_\_\_\_\_ (30 Minutes) EXTENDED HOME \_\_\_\_\_ (60+ Minutes)

Name of Therapist: \_\_\_\_\_ Type of Therapy: \_\_\_\_\_

**Circle Below: Missed : X, Makeup: M, Regular: R & AM / PM**

**Indicate Below: Child Cancel = C / Provider Cancel = P**

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

Date \_\_\_\_\_ Time In \_\_\_\_\_ Out \_\_\_\_\_ AM / PM X M R \_\_\_\_\_

CPT Code \_\_\_\_\_

CPT Code \_\_\_\_\_

CPT Code \_\_\_\_\_

CPT Code \_\_\_\_\_

CPT Code \_\_\_\_\_

CPT Code \_\_\_\_\_

CPT Code \_\_\_\_\_

CPT Code \_\_\_\_\_

CPT Code \_\_\_\_\_

CPT Code \_\_\_\_\_

CPT Code \_\_\_\_\_

CPT Code \_\_\_\_\_

CPT Code \_\_\_\_\_

CPT Code \_\_\_\_\_

CPT Code \_\_\_\_\_

ICD-9 Code \_\_\_\_\_

Therapist's Signature \_\_\_\_\_

IFSP Effective Date: \_\_\_\_\_

IFSP End Date: \_\_\_\_\_

# Units Approved	# Units Used to Date	# Units Used This Session	# Units Left

Total Number of Sessions \_\_\_\_\_

**PERSONAL BILLING FOR SERVICES**

\_\_\_\_\_ BASIC HOME \$ \_\_\_\_\_ /HALF HR # of Sessions \_\_\_\_\_ @ \$ \_\_\_\_\_ = \_\_\_\_\_

LMECC Signature EXTENDED HOME \$ \_\_\_\_\_ /HR PLUS # of Sessions \_\_\_\_\_ @ \$ \_\_\_\_\_ = \_\_\_\_\_