**Minnesota Department of Human Services Telemedicine Services**

**Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) Services Documentation Log**

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| STUDENT’S NAME | DATE OF BIRTH | ICD-10-CM CODE | SCHOOL NAME |
| Click here to start. Enter text and “tab” to next box. |   |   |   |

\*ICD-10-CM Code – Informational only – not required on this form. ICD-10-CM must be reported on claim. Verify procedure codes, modifiers and units chart to ensure proper and correct billing.

 **TYPE OF SERVICE PROVIDED (SERVICE CODE) – check one**

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| **Click and choose from drop down list**. |
| Staff InitialsClick or tap here to enter text. | \*Telemedicine services were deemed appropriate for this student. The session was provided using district approved HIPPA compliant software.Click or tap here to enter text. |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DATE OF SERVICE** | **START TIME (must use am/pm)** | **END TIME (must use am/pm)** | **Total Minutes Spent Providing Service** | **Number of Children in the Group** | **MODE OF SERVICE** | **ORIGINATING SITE (CHILD)** | **DISTANT SITE (PROVIDER)** | **DESCRIPTION OF SERVICES** (Enter a description of the actual services provided relating to goals/objectives on the IEP/IFSP, including: activities, results, response, progress, and plan for next session. Please use black pen. Use as many lines as necessary to complete documentation. Do NOT use pencil, white-out, ditto marks, or arrows. |
| Click on arrow  |   |   |   |   |   |   |   |   |
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 **Total time for all services:** Click or tap here to enter text.

It is a federal crime to provide false information on service billings for Medical Assistance payments. Your signature verifies the time and services entered are accurate and that the services were performed as specified in the child’s care plan.

SERVICE PROVIDER NAME (Type or print) TITLE SIGNATURE

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