Confirmation of Service Delivery Sheet

CHILD'S NAME	CHILD'S EI #	DATE OF BIRTH	AGENCY NAME	AUTHORIZATION #	MONTH/YEAR
			PROSPECT KIDS, LLC		
PROVIDER NAME	**NPI #**	**SERVICE TYPE**	**FREQUENCY**	**DURATION**	**CPT CODE#**

DATE OF SERVICE	START TIME	END TIME	ATTENDANCE TYPE R=REGULAR M=MAKE-UP A=ABSENT / MISSED	PARENT/GUARDIAN/ VERFIYING WITNESS SIGNATURE	DATE SIGNED

I certify that the above named child received all the services noted and that documentation is securely maintained in the child's record. This document verifies the delivery of said services in accordance with all Federal, State and Local laws and regulations governing the Center for Medicaid Services (CMS).

Therapist Signature: _____ Credentials: _____ Date: _____