Service Record – IEP Updated Treatment Plan

Medicaid Number	Last Name	First Name
	Diagnosis Code	**School**

County	Beginning Date	Ending Date	Procedure Code	Units
			H2000 TS	1

IEP UPDATE TREATMENT PLAN (H2000 TS)

1. Contacted/sent notice to parent/guardian re: IEP Team meeting(s) _____
2. Finalized IEP Date _____

IEP TEAM LEADER'S SIGNATURE _____ **DATE** _____

Note: Documentation for Step 2 is the IEP form. The date for Step 2 is the date on the form. Medicaid does not reimburse for duplicate services.