MassHealth
Commonwealth of Massachusetts
Division of Medical Assistance
www.mass.gov/dma

Municipal Medicaid Service Documentation Form

School district name	Provider no.
Student name	Service period, year
Student's MassHealth ID	Date of birth

Date	Activity/Procedure Notes	Individual or Group (circle one)	Service Time
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X _____ _____ _____
Provider's signature Title Date

X _____ _____ _____
Supervising professional's signature *(required for services provided "under the direction of")* Title Date

MMSDF (10/03)