Confirmation of Service Delivery Sheet

Child's Name	Child ID#	Date of Birth	Agency Name	Agency NPI#	Authorization #	Month/Year
			Tender Age PT Inc.	1598810970		

Type of Service	Provider Name/License Number/NPI#	Mandate	Region	ICD-10 Code

Date of Service	Start Time	End Time	Attendance Status	Missed Session Date (If applicable)	CPT Code(s)	Parent/Guardian/Verifying Witness Signature	Date Signed

I certify that on the dates above, the above named child receive the services noted and that documentation exists and is maintained on file verifying the delivery of said services in accordance with all relevant federal, state and local laws and regulations governing the Medicaid process.

Therapist Signature: _____ **Credentials:** _____ **Date:** _____