Behavioral Health Treatment
Parent Verification Receipt

Child's Name:	**Date of Birth:**	**Medi-Cal ID #:**
BHT Provider Name:	**Provider Phone #:**	**Caregiver/Legal Guardians:**
Authorized Hours Per Code:	**Date Submitted to L.A. Care:**	**Reflected Month:** ☐Jan ☐Feb ☐Mar ☐April ☐May ☐Jun ☐Jul ☐Aug ☐Sep ☐Oct ☐Nov ☐Dec

Date	Location	Description of Service Provided	Start Time	End Time	Services Code and Modifier	Provider Name and Credentials	Caregiver Signature

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This form applies to the following service codes:

H2019-HP	Direct Intensive ABA Treatment (provided by BCBA-D, Licensed MA/MS, BCBA)
H2019-HC	Direct Intensive ABA Treatment (provided by BCaBA, MA/MS)
H2019-HN	Direct Intensive ABA Treatment (provided by Paraprofessional-BA/BS)
H2019-HH	Direct Intensive ABA Treatment (provided by Paraprofessional-High school degree)
H0031- HP	Intensive ABA Services-Case Supervision Direct or Indirect (rendered by BCBA or Licensed MA/MS)
H0031-HC	Intensive ABA Services-Case Supervision Direct or Indirect (provided by BCaBA or MA/MS)
H0031-HN	Intensive ABA Services-Case Supervision Direct or Indirect (rendered by BA/BS*)
S5111-HP	Parent Education Training – (provided by BCBA or Licensed)
S5111-HC	Parent Education Training – (provided by BCaBA or MA)
S5111-HN	Parent education Training – (Provided by BA/BS*)
H2014	Social Skills Group

Instructions for Caregiver or Legally Appointed Guardians: Please sign, date, and submit this form to your vendor within 30 days from the time the services were provided. If you are unable to sign the form, please contact your L.A. Care Behavioral Health Treatment department as soon as possible. If you have any questions, please feel free to contact L.A. Care's Behavioral Health Treatment department.

I verify that the Behavioral Services provided to the consumer listed on this form were provided at the location, dates, and times as shown and are true, correct, and complete.

Name of Caregiver/Legally Appointed Guardian: _____

Caregiver or Legally Appointed Guardian: _____