**Authorization #:**

**Member Name:**  **Member Identification Number:**

**Qualified Autism Service Provider Name:**

**NPI #:** **Provider Phone #:** ( )

**Services Provided:** **Month** **Year**

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| **Date:** | **Location:** | **Name & Credential of Person Providing Services** | **CPT/HCPC Code:** | **Start Time** | **End**  **Time** | **Total**  **Time:** | **Parent/Guardian**  **Signature** |
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| **Date:** | **Location:** | **Name & Credential of Person Providing Services** | **CPT/HCPC Code:** | **Start Time** | **End**  **Time** | **Total**  **Time:** | **Parent/Guardian**  **Signature** |
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