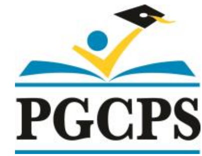
Medicaid Recovery Office
INITIAL IEP ONLY STUDENT FORM



Please complete the information below and attach the required documentation.

Student Information	
Date of Service (mm/dd/yyyy):	
Student Name:	Gender (circle): M F
Date of Birth *(mm/dd/yyyy):*	Disability Code:
Student ID Number:	Place of Service:
Medical Assistance Number:	

Service Type
☐ Initial IEP (*I have included all of the documentation below*) ☐ Copy of meeting Sign-In Sheet ☐ Completed Case Manager Letter (*with your name as Case Manager*) ☐ Signed Parental Consent

***Provider Name*:** ________________________________

Provider Signature:______________________________ ***Date:***__________________

Prince George's County Public Schools
Medicaid Recovery Office
Sasscer Administration Building ▪ 14201 School Lane, C05-451 ▪ 301.952.6349 (office) ▪ 301.780.5925 (fax)