S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE *BILLED TO DSN BOARD*

TO: _____

_____

RE: _____
Recipient's Name / **Date of Birth**

_____
Address

Medicaid # /___/___/___/___/___/___/___/___/___/___/___/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Community Services:

Number of Units Per Week: _____ (one unit = 1/2 day or 2-3 hours)

Service Coordinator/Early Intervention: Name / Address / Phone # (Please Print):

_____

_____

_____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form CS- 06 (08/09)

Sample