Oregon Center
for Children & Youth
with Special Health Needs

Oregon Commission
on Autism Spectrum Disorder

ASD Identification Team
Provider Reimbursement Request

Team Site ________________________________ **Date** _________________

Provider Name	
Date Range for Reimbursement	
TOTAL TIME SPENT (Include time spent examining, evaluating, writing reports, consulting, and meeting about child(ren) for the ASD Identification project)	_________________ HOURS

Submit to OCCYSHN, attn: Matt Gonzalez
FAX: 503.494.2755
Email: gonzamat@ohsu.edu