Physician's Prescription for Services

Schenectady County Public Health Services

Children with Special Needs Program

Child's Name: _____ DOB: _____

School District: _____

Required ICD-10

☐ Speech Therapy

Frequency/Duration: ind x 30/wk grp x 30/wk _____ _____

Reason/Need for ST: _____ _____

☐ Occupational Therapy

Frequency/Duration: ind x 30/wk grp x 30/wk _____ _____

Reason/Need for OT: _____ _____

☐ Physical Therapy

Frequency/Duration: ind x 30/wk grp x 30/wk _____ _____

Reason/Need for PT: _____ _____

☐ Other Services approved by district:

ind x 30/wk grp x 30/wk _____

ind x 30/wk grp x 30/wk _____

Dates Effective: (dates on IEP)
(Select only one)

☐ School Year _____ to _____

☐ Summer (ESY) _____ to _____

Below area is **REQUIRED** for the Physician, NP or PA to fill out.

Physician's (NP or PA) Name (print):	Original Signature (NO STAMPS):	Date (mm/dd/yy):
Title:	License #:	NPI #:
Supervising/Attending physician:	Attending physician signature:	Attending physician NPI #:

Please Note: The areas below can be stamped

Please return to:

Provider's Contact Information:	Physician's Contact Information:
Office Stamp can be used or pre-printed address & telephone number) Name: Address1: Address 2: city,state,zip Phone #: Fax # (if available):	(Office Stamp can be used or pre-printed address & telephone number) Name: Address1: Address 2: city,state,zip Phone #: Fax # (if available): Medicaid Provider ID #, if applicable:

TO PROVIDER: SEND SCRIPT WITH FIRST BILLING CYCLE PERTAINING TO THIS ORDER. rev. 7.23