Schenectady County Public Health Services

Children with Special Needs

SPEECH PATHOLOGIST'S RECOMMENDATION FOR SPEECH SERVICES

⁂ (Must be enrolled in Medicaid to submit this form) ⁂

****Provider's Contact Information:**

*(**Office Stamp** can be used or pre-printed address & telephone number)*

Name:

Address1:

Address 2:

City, State, Zip:

Phone Number:

Fax # (if available) :

I, _____ recommend that
Licensed Speech Pathologist (print)

speech/language services be provided to _____
child's name (print)

date of birth _____ .

Recommended speech services:

☐ **speech evaluation**

☐ **IEP:** Frequency: _____ ind x 30/wk _____ grp x 30/wk _____

Dates covered _____ to _____
mm/dd/yy mm/dd/yy

Required ICD – 10 Code(s): _____

Reason/Need for ordered services: _____

License Number: _____

NPI Number: _____

⁂ **Medicaid Provider ID Number:** _____

_____ _____
Speech Pathologist Signature (with credentials) **Date** (mm/dd/yy)

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