Physician's Prescription for Services



Children with Special Needs Program

Child's Name:			DOB:			
School District:						
Speech Therapy						Required ICD-10
Frequency/Duration:	ind x 30/v	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 dis	ind x 30/wl		grp x 30/wk			
	ind x 30/wl	k	grp x 30/wk			
Dates Effective: (dates on IEP) (Select only one)	School Y	_		to		
	Summer ((ESY)		to		
Below area is REQUIRED for the						
Physician's (NP or PA) Name (print):	Original Sign	Original Signature (NO STAMPS):			Date (n	nm/dd/yy):
Title:	License #:	License #:			NPI #:	
Supervising/Attending physician: Attending		nysician si	gnature:		Attend	ing physician NPI #:
Please return to:	Please Note: The	e areas belo	ow can be stamped			
Provider's Contact Information	ation:		Physician's (Conta	act Info	rmation:
Office Stamp can be used or pre-printed address & telephone number)			(Office Stamp can be used or pre-printed address & telephone number)			
Name:		Name Addre				
Address1:		Addre				
Address 2:			tate,zip			
city,state,zip		Phone				
Phone #:	Fax # (if available):					
Fax # (if available):	Medicaid Provider ID #, if applicable:					