PRESCRIPTION/RECOMMENDATION FOR PRESCHOOL SERVICES

Student's Name:_____ DOB: _____

School:_____ OSIS#:_____

District: _____

Period of Service
School year September 4th, 2019 – June 26th, 2020

I have reviewed the recommendations on the student's IEP with respect to the therapies below and in my opinion, the following services are deemed medically necessary:

Diagnosis (ICD-9 & ICD-10 code) REQUIRED
You must provide the MOST SPECIFIC ICD CODE(S) for each service checked.

Service/Therapy ****Must use an ICD-9 & ICD-10 code for each service selected**		
☐Occupational Therapy	ICD-9 Code_____	ICD-10 Code_____
☐Physical Therapy	ICD-9 Code_____	ICD-10 Code_____
☐Speech Therapy	ICD-9 Code_____	ICD-10 Code_____
☐Psychological Counseling	ICD-9 Code_____	ICD-10 Code_____

Physician/Physician's Assistant/Nurse Practitioner Information:

	(Please Print)	**(Stamp)**
Name:		
Address:		
Phone Number:		
License #(**REQUIRED**):		
NPI #(**REQUIRED**):		
Medicaid Provider ID #(**REQUIRED**):		

_____ _____

Signature of Physician/Physician's Assistant/Nurse Practitioner
Date Signed

***Must be hand written signature**; **STAMPED SIGNATURE WILL NOT BE ACCEPTED**

Note: Medicaid requires that all services recommended by a Physician, Physician's Assistant, Nurse Practitioner must be signed **prior to or on** the start date of services.