Physician's Prescription for Services

Child's Name:_____ DOB:_____

School District:_____ County: _____

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 Service/Therapy: _____

Frequency/Duration: _____ind x 30/wk_ _____grp x 30/wk _____

Reason/Need: _____

Dates Effective (dates on IEP) : ☐ School Year _____ to _____

*Select only one ☐ Summer (ESY)_____ to _____

This section Must Be Completed by the Physician, NP or PA		
Name of Physician/NP/PA (please print):	**Original Signature (NO STAMPS):**	**Date (mm/dd/yy):**
Title:	**NPI #:**	**License #:**
Medicaid Provider ID #, if applicable:		

Please Note: The areas below can be stamped

Please return to Provider:	Please return to Physician:
Name:	Name:
Address1:	Address1:
Address 2:	Address 2:
City,State,Zip	City,State,Zip
Phone #:	Phone #:
Fax #:	Fax #: