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	
Address 1:	
Address 2:	
City, State, Zip	
Phone Number:	
Fax # (if available):	

I, _____
Licensed Speech Pathologist (print)

Recommend that speech/language services be provided to

_____
Print Child's Name Date of Birth

Recommended Speech Services

( ) Speech Evaluation

( ) IEP

Frequency	Dates
_____ Individual x 30 Minutes per Week	
_____ Group x 30 Minutes per Week	

Required ICD – 9 Code(s): _____

Required ICD – 10 Code(s): _____

Reason/Need for ordered services: _____

License Number: _____

NPI Number: _____

Medicaid Provider ID Number: _____

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