



# Physician's Prescription for Services

## Children with Special Needs Program

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

School District: \_\_\_\_\_

### 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 Services approved by district:

\_\_\_\_\_ ind x 30/wk \_\_\_\_\_ grp x 30/wk  
\_\_\_\_\_ ind x 30/wk \_\_\_\_\_ grp x 30/wk

**Dates Effective: (dates on IEP)**  
(Select only one)

School Year \_\_\_\_\_ to \_\_\_\_\_

Summer (ESY) \_\_\_\_\_ to \_\_\_\_\_

Below area is **REQUIRED** for the Physician, NP or PA to fill out.

Physician's (NP or PA) Name (print):	Original Signature (NO STAMPS):	Date (mm/dd/yy):
Title:	License #:	NPI #:
Supervising/Attending physician:	Attending physician signature:	Attending physician NPI #:

Please Note: The areas below can be stamped

Please return to:

<p align="center"><b>Provider's Contact Information:</b></p> <p>Office Stamp can be used or pre-printed address &amp; telephone number)</p> <p>Name: Address 1: Address 2: city,state,zip Phone #: Fax # (if available):</p>
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<p align="center"><b>Physician's Contact Information:</b></p> <p>(Office Stamp can be used or pre-printed address &amp; telephone number)</p> <p>Name: Address 1: Address 2: city,state,zip Phone #: Fax # (if available): Medicaid Provider ID #, if applicable:</p>
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