Schenectady County
Public Health Services

Children with Special Needs

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:
Address1:
Address 2:
City, State, Zip:
Phone Number:
Fax # (if available) :

I, ____ recommend that
Licensed Speech Pathologist (print)

speech/language services be provided to ________________________________
child's name (print)

date of birth ______________ .

Recommended speech services:

( ) **speech evaluation**

( ) **IEP:** Frequency: ind x 30/wk grp x 30/wk

Dates covered ________________ to ________________
mm/dd/yy mm/dd/yy

Required ICD – 10 Code(s):________________________________

Reason/Need for ordered services: ________________________________

License Number: ________________________________

NPI Number:________________________________

⁂ **Medicaid Provider ID Number:**________________________________

________________________________ ________________

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

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