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**PRESCRIPTION/RECOMMENDATION FOR SCHOOL AGE SERVICES**

Student’s Name: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School/Provider: District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Agency, Center Based School or Individual Provider)

The child named above is recommended for the following service(s). Services when provided will be in accordance with the Individualized Education Program designed by the Committee.

Period of Service: School Year **7/1/15 - 6/30/16**

**Diagnosis (ICD-9 & ICD-10 code) REQUIRED**

**You must provide the MOST SPECIFIC ICD CODE(S) for each service checked.**

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| Service/Therapy**\*\* Must use an ICD-9 & ICD-10 code for each service selected** |
| [ ]  OT ICD-9 Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD-10 Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  PT ICD9 Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD-10 Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Speech ICD9 Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD-10 Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Psych Co\* ICD9 Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD-10 Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  NU\*\* ICD9 Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD-10 Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

\*Psych Co = Psychological Counseling Services

\*NU= nursing services (In addition to the prescription, a specific Dr.’s order with detailed instructions is required).

Physician/Physician’s Assistant/Nurse Practitioner/SLP Information:

(please print or use stamp):

|  |  |
| --- | --- |
| Name: |  |
| Address: |
|  |
| Phone Number: |
| License # **(REQUIRED)** |
| NPI # **(REQUIRED)** |
| Medicaid # **(REQUIRED)** |

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Signature of Physician/P.A./Nurse Practitioner/SLP 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 or Licensed Speech Pathologist must be signed **prior to or on** the start date of services.

A FACSIMILE OR PHOTOCOPY OF THIS FORM IS ACCEPTABLE