

# Physician Prescription for Services

Based on a review of the child’s records, I am referring this child for the following service(s):

Student’s Name: DOB: ­­

Agency/School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Agency, Center Based School or Individual Provider)

|  |
| --- |
|  Type Of Services(Please circle any that apply) |
| [ ]  Audio [ ]  Neuro [ ]  Ortho [ ]  Psy [ ]  Psychiatric [ ] O T PT [ ] [ ] ST   |

**Diagnosis (ICD 10 code) REQUIRED for Services provided on or after 10/01/2015.**

**Diagnosis (ICD 9code) REQUIRED for Services provided *prior to* 10/01/2015.**

 Note: Please provide an ICD9 and an ICD 10 code for each service selected

|  |  |
| --- | --- |
| \*REQUIRED Reason for Evaluation (ICD 9, ICD-10 Code or Presenting Problem) |  |

Physician/Physician’s Assistant/Nurse Practitioner Information

(Please print or use stamp):

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

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Signature of Physician/Physician’s Assistant/Nurse Practitioner Date

**Must be original signature: STAMPED SIGNATURE WILL NOT BE ACCEPTED**

A FACSIMILE OR PHOTOCOPY OF THIS RX IS ACCEPTABLE.