

# 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: ­­

ID#:

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) |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.