

**NASSAU COUNTY
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program**
60 Charles Lindbergh Blvd. Suite 100, Uniondale, New York 11553-3683

PRESCRIPTION FOR PRESCHOOL BASED RELATED SERVICES

Student's Name: _____ DOB: _____

Agency/School _____ District: _____
(Agency, Center Based School or Individual Provider)

Period of Service
<i>School year 07/01/2022 – 06/30/2023</i>

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.

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

<u>Service/Therapy</u>	
(Please check any that apply)	
Require: ICD-10 Code for each service.	
<input type="checkbox"/> OT	ICD-10 Code _____
<input type="checkbox"/> PT	ICD-10 Code _____
<input type="checkbox"/> Speech	ICD-10 Code _____
<input type="checkbox"/> Psy Co*	ICD-10 Code _____
<input type="checkbox"/> NU**	ICD-10 Code _____

*Psy 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 Information

(Please print):

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

*Signature of Physician/Physician's Assistant (P.A.)/Nurse Practitioner

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