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
School year 07/01/2024 – 06/30/2025

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

Service/Therapy (Please check any that apply) **Require: ICD-10 Code for each service.**
☐ OT ICD-10 Code _____
☐ PT ICD-10 Code _____
☐ Speech ICD-10 Code _____
☐ Psy Co* ICD-10 Code _____
☐ 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

January 2024 Revised