**Physician or Other Practitioner of the Healing Arts
Recommendation For Children’s Habilitation Intervention Services**

| **Section #1: Individual’s Information** |
| --- |
| First Name:  | Last Name: |
| Medicaid ID #:  | Birthdate: |
| Email Address: | Phone Number: |
| Parent/Decision Making Authority Name:  |
| ☐ I am the above listed individual’s parent/decision making authority and I am giving consent to request a physician’s recommendation for Children’s Habilitation Intervention Services.Parent/Decision Making Authority Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Return this form to the contact listed in Section #2**

| **Section #2: Contact Information** |
| --- |
| Contact Person Name: Missy Garst | Phone Number: (262)705-4326 |
| Email Address:missyg@hingepointyh.com | Fax (if applicable):  |
| Address:  |

| **Section #3: Physician or Other Practitioner of the Healing Arts Information & Recommendation Section**  |
| --- |
| Physician Name:  |
| Phone Number: |
| Address:  |
| NPI Number (if needed):  |
| x I am recommending Children’s Habiltiation Intevenion Services for the child listed above. ☐ I do not agree with the recommendation. Reason for disagreement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature and Credential: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |