PRESCRIPTION FOR PRESCHOOL/SCHOOL AGE BASED RELATED SERVICES

Student's Name: _____ DOB: _____

Agency/School: The Children's Learning Center District: _____

Period of Service
School year 7/1/2024 - 6/27/2025

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: most specific ICD-10 Code for each service.**
OT ICD-10 Code _____
PT ICD-10 Code _____

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 handwritten 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, FAX TO 516-377-2118.

Revised 03- 2024