

THRIVE



—PEDIATRIC CLINIC—

2300 130th Ave NE # 102, Bellevue, WA 98005 | 425-590-9269 | www.ThrivePediatricClinic.com

Dear Physician:

Your patient _____ is seeking occupational therapy services with us.

Although occupational therapists outside of a hospital are not required to work under a physician's referral, insurance companies often require documentation of a physician's referral for consideration of reimbursement. The state of WA is a limited direct access state for OT services. Meaning you DO NOT need a referral to see an OT for an evaluation (e.g first appointment). In order to facilitate processing of insurance claims, a physician's referral with diagnosis is highly recommended.

In the absence of other diagnoses, the following may best describe the difficulties experienced by many of the children seen in our clinic:

M62.81 Muscle Weakness (Generalized)

R13.10 Dysgraphia

G70.2 Congenital and/or Developmental Myasthenia or

F82 Specific Developmental Disorder of Motor Function If the child has adequate coordination but has suspected sensory issues, some physicians use the diagnosis

F93.9 Childhood Emotional Disorder, Unspecified or

G96.9 Disorder of Central Nervous System, unspecified

Given a release of information, we would be happy to speak with you if there are questions about a diagnosis or our services.

Please fill out the attached, accompanying form and mail it to the address below, fax to **Fax Number # (844) 441-1839 Direct Number #(425) 590-9269** or email to admin@thrivepediatricclinc.com. Thank you for your support of this child and family.

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REFERRAL FOR PEDIATRIC OCCUPATIONAL THERAPY

Child's name: _____

Date of Birth: _____

CHECK ONE: once a week _____ twice a week _____

If more than one diagnosis is used please indicate primary with an *

- ___ M 62.81 Muscle Weakness (Generalized)
- ___ R13.10 Dysgraphia
- ___ G70.2 Congenital and/or Developmental Myasthenia
- ___ F82 Specific Developmental Disorder of Motor Function
- ___ R29.3 Abnormal Posture, Head Position
- ___ G80 Cerebral Palsy; specify type: _____
- ___ G96.9 Disorder of Nervous System, Unspecified
- ___ R63.3 Feeding Difficulties, Oral Aversion
- ___ F50.9 Eating Disorder, Unspecified
- ___ F51.01 Primary Insomnia, Difficulty Initiating or Maintaining Sleep
- ___ F84.9 Pervasive Developmental Disorder, Unspecified
- ___ F84.0 Autism Spectrum
- ___ F90.2 Attention Deficit Hyperactivity Disorder
- ___ F84.2 Rett Syndrome
- ___ Q99.2 Fragile X Syndrome
- ___ Q90.9 Down Syndrome, Unspecified
- ___ F41.1 Generalized Anxiety Disorder;
- ___ F41.9 Anxiety, Unspecified;
- ___ F40.8 Other Phobic Anxiety Disorders
- ___ F93.9 Childhood Emotional Disorder, Unspecified
- ___ R45.89 Emotional Dysregulation
- ___ Other: _____ (specify)

Physician name _____ Address _____ License Number _____

I verify that the services requested are medically necessary for the above-named patient.

Signature: _____ Date: _____

NPI# _____

Please submit this form via the following:

Fax Number # (844) 441-1839 or email to admin@thrivepediatricclinc.com.