Krista Legge
Executive Director
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Prescription for School Aged Based Related Services

Student's Name: ______________________ DOB: _______________

District: ____________________ School: _______________

The child named above has been recommended for the following service(s) by his/her school district. The frequency and duration of services will be as dictated on the IEP.

Period of Service: School Year **7/1/2024 – 6/30/2025**

Service/Therapy
(Please check any that apply.)
An ICD 10 CODE is *required* for each service selected

☐ OT ICD 10 Code _______ ☐Group ☐Individual Frequency: ______

☐ PT ICD 10 Code _______ ☐Group ☐Individual Frequency: ______

☐ SP ICD 10 Code _______ ☐Group ☐Individual Frequency: _____

☐ OT Evaluation ICD 10 Code _______

☐ PT Evaluation ICD 10 Code _______

Physician/Physician's Assistant/Nurse Practitioner Information (please print or use stamp):

Name: ____________________________

Address: ____________________________

____

Phone: ____________________________

License Number # (REQUIRED): ____________________________

NPI # (REQUIRED): ____________________________

Medicaid # (REQUIRED): ____________________________

X ___________________________________ Date: _______________

Signature of Physician/P.A./Nurse Practitioner
(Must be original signature, stamped signature will not be accepted) **Note:** Medicaid requires that all services recommended by a physician, physician's assistant, or nurse practitioner must be signed prior to the start date of services.