

Doctor, Nurse Practitioner or Physician Assistant
Order for School Health Related Support Services

Student Name: _____
 First _____ Last _____

Birth Date: _____ / _____ / _____ NYC Student ID: _____
 Month Day Year OSIS #

I have reviewed the recommendations on the student's IEP with respect to the therapies below and in my opinion, the following services are deemed medically necessary:

for each therapy on the student's IEP, mark one column and include ICD Code(s)

Please blacken a circle only for services on the IEP

	Service IS Medically Necessary	Service, as written, IS NOT Medically Necessary	ICD Code(s) associated with each service
Occupational Therapy	<input type="radio"/>	<input type="radio"/>	_____ _____
Physical Therapy	<input type="radio"/>	<input type="radio"/>	_____ _____
Speech Therapy	<input type="radio"/>	<input type="radio"/>	_____ _____

Ordering Doctor, PA or NP's Signature (an original signature is required)

Date

Ordering Doctor, PA or NP's Name

Ordering Doctor, PA or NP's License Number

Address (Street)

Ordering Doctor, PA or NP's NPI Number

Address (City, State, ZIP)

Ordering Doctor, PA or NP's Medicaid Provider ID Number

Telephone Number