# 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 | ◯ | ◯ | |
| Physical Therapy | ◯ | ◯ | |
| Speech Therapy | ◯ | ◯ | |

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