Date

Dear _____:

This is to inform you that your patient, _____, DOB: _____, has entered into the Preschool Supportive Health Services Program. For this program, it is necessary to obtain prescriptions for the necessary therapies as indicated by the child's Individualized Education Plan (IEP) and ICD-10 Code (s) of_____as identified in the child's evaluation.

Service		**Frequency/Intensity**	**Authorized Dates of IEP**
_____	Physical Therapy	_____X_____ min. per week (_____I _____G)	_____-_____
_____	Occupational Therapy	_____X_____ min. per week (_____I _____G)	_____-_____
_____	Speech Therapy	_____X_____min. per week (_____I _____G)	_____-_____
_____	Evaluation:	_____Audiological _____Speech _____Occupational Therapy	
		_____Physical Therapy _____Other (please indicate)_____	

PHYSICIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S PRINTED NAME:_____

PHYSICIAN'S ADDRESS_____

PHYSICIAN'S TELEPHONE NUMBER_____

PHYSICIAN'S NPI NUMBER_____

PHYSICIAN'S LICENSE NUMBER_____

PHYSICIAN'S MEDICAID PROVIDER NUMBER_____

*This script is required in accordance with the Therapists' Practices Acts and therapy **CANNOT** begin until receipt of a **signed** and **dated** prescription is received.*

Sincerely,