**NASSAU COUNTY**

**DEPARTMENT OF HEALTH**

**OFFICE OF CHILDREN WITH SPECIAL NEEDS**

**Preschool Special Education Program**

60 Charles Lindbergh Blvd. Suite 100, Uniondale, New York 11553-3683

**PRESCRIPTION FOR PRESCHOOL BASED RELATED SERVICES**

Student’s Name: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency/School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Agency, Center Based School or Individual Provider)

|  |
| --- |
| Period of Service |
| *School year 7/1/18 - 6/30/19* |

The child named above is recommended for the following service(s). Services when provided will be in accordance with the Individualized Education Program designed by the Committee.

Note: Please provide an ICD-10 code for each service selected

|  |
| --- |
| Service/Therapy  (Please check any that apply)  **Require: ICD-10 Code for each service.** |
| OT ICD-10 Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_  PT ICD-10 Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Speech ICD-10 Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Psy Co\* ICD-10 Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_  NU\*\* ICD-10 Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

\*Psy Co = Psychological counseling services

\*\*NU= nursing services (In addition to the prescription, a specific Dr.’s order with detailed instructions is required).

Physician/Physician’s Assistant/Nurse Practitioner Information

(Please print):

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
|  |  |
| Phone Number: |  |
| License # (REQUIRED) |  |
| NPI # (REQUIRED) |  |
| Medicaid Provider # (REQUIRED) |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

**\*Signature of Physician/Physician’s Assistant (P.A.)/Nurse Practitioner**  Date Signed

**\*Must be hand written signature: STAMPED SIGNATURE WILL NOT BE ACCEPTED**

**Note**: Medicaid requires that all services recommended by a Physician, Physician’s Assistant, Nurse Practitioner or Licensed Speech Pathologist must be signed **prior to or on** the start date of services.

A FACSIMILE OR PHOTOCOPY OF THIS FORM IS ACCEPTABLE

Revised 02- 2018