MEDICAID PHYSICIAN AUTHORIZATION FORM

______________County Schools

Student's Full Name ________________________________ Date __________________________

School ____ Date of Birth __________________

Parent(s)/Guardian(s) ______________________________ Grade _________________________

Address ____ WVEIS# ______________________

City/State/Zip______________________________________ Telephone ____________________

Medicaid number: ____

Please review and authorize the services that are included on your patient's Individualized Education Program and Services Care Plan. Thank you for your assistance.

TO: ____

Physician's Name (Please Print)

____

Address

____

City/State/Zip

The following services have been included on the student's Individualized Education Program and Service Care Plan.

Service	Service included on Individualized Education Program and Service Care Plan	Frequency/ Duration	Evaluation Reevaluation	Diagnosis Codes - ICD – 10 Code(s) that justify therapy being provided
Physical Therapy				
Occupational Therapy				
Speech Therapy				
Audiology				
Psychotherapy				

Targeted Case Management may be provided based upon medical necessity.

The Physician Authorization may also be signed by Physician Assistant (PA) or an Advanced Practice Registered Nurse (APRN). Authorization is valid for one calendar year:

I authorize the above identified services and/or evaluations as medically necessary and refer this student for services/evaluation.

_________________________________ _________________

Physician/ PA/ APRN Signature Date of Referral

Return the signed form to:

Name ____

County ____

Address ____

City/State/Zip _______________________________________