MKSA
Early Start - Bright Future

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Speech Referral for Recommendation for Services

(You must complete a separate form for each.)

A Speech and Language referral for ☐ **services** is recommended in accordance with the request by the Early Intervention Program
Services, when provided, will be in accordance with the IFSP designed by the Early Intervention designee and parent / guardian.

Student Name: _____

Date of Birth: _____

EI Number _____

Period of Service: Per IFSP _____

☐ SERVICES: _____
(Use official **ICD-10 codes**) REQUIRED - Use as many codes as appropriate

_____ ***Signature**: _____
(Please Print Name) **NYS Licensed Speech Pathologist**

Address: _____
Phone: _____ **Title**: _____

MEDICAID PROVIDER #: _____ **DATE**
LICENSE NUMBER: _____ **NPI NUMBER:** _____ **SIGNED:** _____

Note: Medicaid requires that speech evaluations and services be recommended by a Licensed Speech Pathologist, Physician, Physician's Assistant, or Nurse Practitioner **prior to or on** the date of the evaluation or the start of services.

***Must be original signature – Stamped Signature will not be accepted.**
A FACSIMILE OR PHOTOCOPY OF THIS RECOMMENDATION IS ACCEPTABLE.

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