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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

(Please Print Name)

*Signature: _____
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.