MKSA
Early Start - Bright Future

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PRESCRIPTION FOR EARLY INTERVENTION THERAPEUTIC SERVICES

Child's Name: **DOB:**
Doctor's Name **Dr. Fax:**
Child's IFSP Date:

Based on review of the evaluation reports and/or progress reports, it is recommended that the above named child receive the following service. In order to provide this service, we need a current prescription. We have parental consent on file for you to release medical information to us.

Please indicate if there are any medical limitations

☐ There are no restrictions/contra-indications ☐ There are restrictions (attach medical clearance)

EARLY INTERVENTION SERVICES/THERAPY	**FREQUENCY**
_____	Evaluation/ Per IFSP
_____	Evaluation/ Per IFSP

Script is valid for any IFSP frequency/duration recommendation written within one year of date signed

Diagnosis (ICD-10 code) REQUIRED
You must provide the MOST SPECIFIC ICD CODE(S) for each service checked.

Service/Therapy Must specify an ICD-10 code for each service selected	
☐ OT	ICD-10 Code_____
☐ PT	ICD-10 Code_____
☐ Speech	ICD-10 Code_____

****Please have Rx signed by a Medicaid enrolled Physician, PA or NP if possible per NYS Dept. of Health**

Physician/Nurse Practitioner Information:

Name:
Address:

Phone Number:
License #:_____ NPI #: _____ Medicaid Provider #:_____

****Physician/Nurse Practitioner/PA Signature**: _____ Date _____
(Must be original signature)

☐ **NASSAU COUNTY EIP** ☐ **SUFFOLK COUNTY EIP** ☐ **New York City EIP** **Fax to: 516-577-9602**