

# Medicaid OT/PT Prescription from Physician

\_\_\_\_\_ Independent School District

Student Name:

DOB:

Campus:

Medicaid Number:

Student ID#

Current OT/PT Evaluation:

An evaluation for OT/PT determined the need for school based therapy.

Comments:

Signature: \_\_\_\_\_

Printed Name:

Title:

Date of Signature:

NPI: