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**OUTPATIENT PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY PROGRAM****Beneficiary and Provider Information**

**Patient Name:** Enter the beneficiary's first and last name as it appears on the Mississippi Medicaid ID card.

**Date of Birth:** Enter the month, date and year of the beneficiary's birth.

**Age:** Enter the age of the beneficiary at the time service is to be rendered.

**Sex:** Indicate the sex of the beneficiary.

**Date of last visit:** Enter the last date that the beneficiary was seen in the office for evaluation of therapy needs.

**Ordering MD/NP/PA Name (First and Last):** Indicate the name of the ordering MD/NP/PA.

**Medicaid ID#:** Enter the ordering MD/NP/PA Mississippi Medicaid Provider Number.

**Telephone#:** Enter the ordering MD/NP/PA telephone number, including area code and extension.

**Clinical Information****This section is to be completed by the MD/NP/PA**

**Diagnosis and ICD-9-CM-Codes:** Enter the beneficiary's primary and secondary diagnoses for this treatment and enter the ICD-9-CM codes that correspond to the diagnoses.

**Clinical Summary:** Record a relative history indicating the beneficiary's need for each requested therapy service by discipline (physical, occupational and/or speech therapy).

**Physician/Nurse Practitioner/Physician Assistant Order(s):** The physician, nurse practitioner, or physician assistant must write an order for therapy services to include the discipline of therapy (PT/OT/SLP) that will need to evaluate the beneficiary. If known, please include specific modalities or treatments that you want carried out during the course of therapy services.

**Physician/Nurse Practitioner/Physician Assistant Attestation, Signature And Date:** Indicates that the services listed in the clinical summary Section B of this form services ordered as medically necessary by the ordering MD/NP/PA for the beneficiary specified in this form.