

Section A: Beneficiary and Provider Information

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| Patient Name: _____ Medicaid #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Age: <input type="text"/> <input type="text"/> <input type="text"/> Sex: <input type="text"/> (M or F) Date of last visit: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | Ordering MD/NP/PA Name (First and Last): _____ Medicaid ID#: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Telephone #: <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Ext. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
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Section B: Clinical Information
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

| Diagnoses | ICD-9-CM |
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Clinical Summary: Record relative history indicating patient's need for each requested therapy service by discipline, i.e., physical, occupational and/or speech therapy.

Physician/Nurse Practitioner/Physician Assistant Order(s):

Section C: Physician//Nurse Practitioner/Physician Assistant Attestation, Signature and Date

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed services, who knowingly or willfully makes, or causes to be made any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I hereby certify that I am the prescribing physician/nurse practitioner/physician assistant identified in Section A and that I have prescribed the orders listed in Section B of this form. I certify that the medical necessity information in Section B is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution.

Signature and Title of Prescribing Provider **Date**