NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF EARLY INTERVENTION

WRITTEN REFERRAL FROM PRIMARY CARE PRACTITIONER
PRESCRIPTION FOR THERAPEUTIC SERVICES
DOCUMENTATION OF MEDICAL NECESSITY FOR THIRD PARTY CLAIMING

Pursuant to Section 2559(3) (a) (ii) of New York State Public Health Law

Child's Name (First/MI/Last):	**Child's Date of Birth:**
Name of Parent:	**Phone No.:**
Service Coordinator:	**Phone No.:**

Dear Primary Care Practitioner:
Pursuant to New York State Public Health Law Section 2559(3) (a) (ii), parents are required to provide the Early Intervention Program with a written referral from a primary health care practitioner as documentation of the medical necessity of early intervention services for their children who have been found eligible through a multidisciplinary evaluation for the Early Intervention Program. This information is sought in order to facilitate claims and payment processing for these services from third party insurance. The New York State Bureau of Early Intervention developed this form to facilitate a complete and accurate referral. However, you may use the form of your choosing provided it contains all the required information. Thank you for your support in providing the information requested below.

*Patient Assessment and Relevant Medical History

*Diagnosis, including diagnosed condition or developmental delay (and accompanying ICD code), relating to the need for Early Intervention Program services

The above mentioned child is being prescribed the following medical necessary therapeutic services to treat:

*Diagnosed Condition(s) _____ ICD Code(s) _____

*Developmental Delay(s) _____ ICD Code(s) _____

*Please note each prescribed service must have a separate prescription

[ ] Physical Therapy as per frequency and duration agreed to on the IFSP dated _____
[ ] Occupational Therapy as per frequency and duration agreed to on the IFSP dated _____
[ ] Speech Therapy as per frequency and duration agreed to on the IFSP dated _____
[ ] Family Training as per frequency and duration agreed to on the IFSP dated _____
[ ] Vision as per frequency and duration agreed to on the IFSP dated _____
[ ] Special Instruction as per frequency and duration agreed to on the IFSP dated _____
[X] 1 additional make-up session allowable per week per discipline.

I understand that the Early Intervention Program services listed above may require ongoing evaluation/assessment to be conducted on a regular basis by a qualified professional to evaluate the progress of the child.

Based on the above, I refer _____ to the Early Intervention Program to obtain the services identified in his/her IFSP.

*Physician/Nurse Practitioner Signature: _____ Date: _____
(Signature must not be a stamp)

*Physician/Nurse Practitioner Name (Print): _____ Phone No.: _____

*Physician/Nurse Practitioner Address: _____

*New York State License No.: _____ NPI No.: _____

Return form to: _____ Fax: _____