DRAFT_Physician Recommendation

For Children's Habilitation Intervention Services

Section #1: Individual's Information	
First Name:	Last Name:
Medicaid ID #:	Birthdate:
Parent/Decision Making Authority Name:	Phone Number:

Section #2: Children's Habilitation Intervention Provider Information	
Provider Name:	
Contact Person Name:	
Email Address:	
Phone Number:	Fax Number:

Section #3: Physician's Information	
Provider Name:	
Email Address:	
Phone Number:	Fax Number:
NPI/Provider Number:	

Section #4: Children's Habilitation Intervention Provider Recommendation
☐ I am requesting a physician's recommendation for Children's Habilitation Intervention Services for the child listed above.

Section #5: Physician Recommendation

☐ I agree with the recommendation for Children's Habilitation Intervention Services for the child listed above.

☐ I do not agree with the recommendation.

Reason for disagreement: ____

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Printed Name: ____

Signature and Credential: ____

Date: ______________________

This form should be returned to the submitting Children's Habilitation Intervention Provider listed in Section #2.

DRAFT