Physician Authorization v 8.31.15

tiny-k
An Early Intervention Network

Enter Local tiny-k Program specific info here

_____
Family Name

_____
Address

_____
City, State, Zip

_____
Child's Name

_____
DOB

Date of Request: _____ **Physician Name:** _____

Street Address: _____ **City, State, Zip:** _____

Phone Number: _____ **Fax Number:** _____

As specified in the child's Individualized Family Service Plan (IFSP), the child listed above qualifies and will receive early intervention services during the time period outlined in the IFSP (refer to the IFSP for specific services).

If/as appropriate, the Early Childhood Intervention (ECI) program (local tiny-k program) may seek reimbursement from the Medical Insurance Carrier/ Kansas Medicaid/ KanCare for some or all of the early intervention services. In order to do that, however, the ECI must obtain the signature of a qualified health care provider.

☐ The above-named child is appropriate to receive evaluation and treatment by qualified professionals as part of an early intervention program. I understand a responsible therapist will revise the program in keeping with the child's progress. Unless I note otherwise, I concur that the child's appropriate diagnosis is ***Delayed Milestones in Childhood, ICD 10 R62.0***

Or

Alternate Diagnosis: _____ICD-10-# _____

Or

☐ I would like to be contacted further regarding this authorization/ prescription.

Your signature certifies the child requires all early intervention service(s) specified in the child's IFSP. In this regard, this document will serve as the required "Physician's Prescription" with respect to those services. This prescription must be renewed annually.

For the period from: _____ to _____

_____ _____
Physician Signature **Date**

Comments:

Please fax or mail to: **[Program Name]**
[Contact Name]
[Address]
[City, State, Zip]
[FAX #:]