

**NASSAU COUNTY  
DEPARTMENT OF HEALTH  
OFFICE OF CHILDREN WITH SPECIAL NEEDS  
Preschool Special Education Program  
60 Charles Lindbergh Blvd, Suite 100, Uniondale, New York 11553-3683**

**PRESCRIPTION FOR PRESCHOOL BASED RELATED SERVICES**

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Agency/School \_\_\_\_\_ District: \_\_\_\_\_  
 (Agency, Center Based School or Individual Provider)

Period of Service
<i>School year 07/01/2023 – 06/30/2024</i>

The child named above is recommended for the following service(s). Services when provided will be in accordance with the Individualized Education Program designed by the Committee.

Note: Please provide an ICD-10 code for each service selected

<u>Service/Therapy</u> (Please check any that apply) Require: ICD-10 Code for each service.	
<input type="checkbox"/> OT	ICD-10 Code _____
<input type="checkbox"/> PT	ICD-10 Code _____
<input type="checkbox"/> Speech	ICD-10 Code _____
<input type="checkbox"/> Psy Co*	ICD-10 Code _____
<input type="checkbox"/> NU**	ICD-10 Code _____

\*Psy Co = Psychological counseling services

\*\*NU= nursing services (In addition to the prescription, a specific Dr.'s order with detailed instructions is required).

Physician/Physician's Assistant/Nurse Practitioner Information

(Please print):

Name:	
Address:	
Phone Number:	
License # (REQUIRED)	
NPI # (REQUIRED)	
Medicaid Provider # (REQUIRED)	

\_\_\_\_\_  
\*Signature of Physician/Physician's Assistant (P.A.)/Nurse Practitioner

\_\_\_\_\_  
Date Signed

\*Must be hand written signature: STAMPED SIGNATURE WILL NOT BE ACCEPTED

Note: Medicaid requires that all services recommended by a Physician, Physician's Assistant, Nurse Practitioner or Licensed Speech Pathologist must be signed prior to or on the start date of services.

A FACSIMILE OR PHOTOCOPY OF THIS FORM IS ACCEPTABLE

Revised 06/01/2019