Dear Parents/Guardians:

In order for Variety Child Learning Center to provide related services to your child (occupational therapy, physical therapy, and/or nursing services), NY State laws require us to collect a current prescription for the 2020-2021 school year for each related service that your district has approved for your child. As per NYS School Supportive Health Services Program, all scripts must contain the information stated below.

(Please Note: Speech therapy and psychological counseling services do not require a prescription. Referral forms will be provided and completed by Variety’s NYS Licensed Speech Pathologists, Licensed School Psychologists, or Licensed Social Workers.)

We kindly request that you obtain a prescription that includes the following information, **without which services cannot begin**:

- Your child’s name clearly written
- **School year 7/1/20-6/30/21**
- Service(s) to be provided (OT, PT, or NU)
- ICD10 code (must be specific to the discipline)
- **Original signature of the doctor required – Stamped signature will NOT be accepted**
- License number, NPI# and Medicaid Provider# of the doctor.

For your convenience, we have enclosed a cover letter and form that your doctor may use to authorize your child’s school based related services.

Please return your prescription in the enclosed envelope or fax it to:

Syosset Campus: 516-368-8308
Levittown Campus: 516-490-3303

Thank you for your help.

Sincerely,

Janice Friedman
CEO

Andrea Rieger
CFO
Dear Physician/Physician’s Assistant/Nurse Practitioner:

According to Medicaid Guidelines, all children receiving OT and/or PT services require a current prescription for the school year which must include:

- Name of the child for whom the order is written
- A discipline specific diagnosis
- Physician/Physician’s Assistant/Nurse Practitioner Information which includes:
  - Name
  - Address
  - Phone Number
  - License Number
  - NPI Number
  - Medicaid Provider ID
  - Hand written Signature. Stamped signatures will not be accepted.

For your convenience, we have provided frequently used ICD 10 codes.

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Discipline</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F82</td>
<td>OT/PT</td>
<td>Specific developmental disorder of motor function</td>
</tr>
<tr>
<td>R62.50</td>
<td>OT /PT</td>
<td>Unspecified lack of expected normal physiological development in childhood</td>
</tr>
<tr>
<td>R62.0</td>
<td></td>
<td>Delayed milestone in childhood</td>
</tr>
<tr>
<td>R27.9</td>
<td>OT/PT</td>
<td>Unspecified lack of coordination</td>
</tr>
</tbody>
</table>

Please note: Speech therapy and psychological counseling services do not require a prescription. Referral forms will be provided and completed by Variety’s NYS Licensed Speech Pathologists, Licensed School Psychologists or Licensed Social Workers.

If you have any questions, please contact the OT/PT Administrative Assistant at 516-921-7171, ext. 2196.
PREScription FOR SCHOOL AGE RELATED SERVICES

Student’s Name: __________________________ DOB: __________________________

Agency/School: Variety Child Learning Center District: __________________________

Variety Child Learning Center (Agency, Center Based School or Individual Provider)

Period of Service

School year 7/1/20 - 6/30/21

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

<table>
<thead>
<tr>
<th>Service/Therapy</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>OT</td>
<td>___________</td>
</tr>
<tr>
<td>PT</td>
<td>___________</td>
</tr>
<tr>
<td>Speech</td>
<td>___________</td>
</tr>
<tr>
<td>Psy Co*</td>
<td>___________</td>
</tr>
<tr>
<td>NU**</td>
<td>___________</td>
</tr>
</tbody>
</table>

*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 handwritten 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 02-2018