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|  |  |  |  |  | |  | | --- | | Medical Practitioner Authorization for SBAP Services | | | | | | | | | | | |  | |
|  |  |  |  |  | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  | | |  | | --- | | **Student's Name:** | |  | |  | | --- | |  | |  | **Date of the Current IEP Meeting:** |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  | | | | | | | | | | | |
|  |  |  |  |  | |  | | --- | | **Participating School Name:** | | |  | | --- | |  | | | | |  |  |
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|  |  |  |  | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Related Services** | **Frequency** | **Projected Start Date** | **Anticipated Duration** | **Group** | **Ind** | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | |  | | --- | |  | |  | |  | | --- | | Audiology | |  | | |  |  |  |  | | --- | --- | --- | --- | |  | |  | | --- | |  | |  | |  |  |  | | |  |  |  | | --- | --- | --- | |  | |  | | --- | |  | | |  |  | | |  |  |  |  | | --- | --- | --- | --- | |  | |  | | --- | |  | |  | |  |  |  | | |  |  |  |  | | --- | --- | --- | --- | |  | |  | | --- | |  | |  | |  |  |  | | |  |  |  |  | | --- | --- | --- | --- | |  | |  | | --- | |  | |  | |  |  |  | | | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | |  | | --- | |  | |  | |  | | --- | | Nursing | |  | | |  |  |  |  | | --- | --- | --- | --- | |  | |  | | --- | |  | |  | |  |  |  | | |  |  |  | | --- | --- | --- | |  | |  | | --- | |  | | |  |  | | |  |  |  |  | | --- | --- | --- | 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Impaired | |  | | |  |  |  |  | | --- | --- | --- | --- | |  | |  | | --- | |  | |  | |  |  |  | | |  |  |  | | --- | --- | --- | |  | |  | | --- | |  | | |  |  | | |  |  |  |  | | --- | --- | --- | --- | |  | |  | | --- | |  | |  | |  |  |  | | |  |  |  |  | | --- | --- | --- | --- | |  | |  | | --- | |  | |  | |  |  |  | | |  |  |  |  | | --- | --- | --- | --- | |  | |  | | --- | |  | |  | |  |  |  | | | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | |  | | --- | |  | |  | |  | | --- | | Special Transportation | |  | | |  |  |  |  | | --- | --- | --- | --- | |  | |  | | --- | |  | |  | |  |  |  | | |  |  |  | | --- | --- | --- | |  | |  | | --- | |  | | |  |  | | |  |  |  |  | | --- | --- | --- | --- | |  | |  | | --- | |  | |  | |  |  |  | | |  |  |  |  | | --- | --- | --- | --- | |  | |  | | --- | |  | |  | |  |  |  | | |  |  |  |  | | --- | --- | --- | --- | |  | |  | | --- | |  | |  | |  |  |  | | | | | | | | | | | | | | |  |
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|  |  |  | |  | | --- | | **Re-Evaluations to be provided throughout the duration of this IEP.**  **Re-Evaluations** **Initial Evaluations** | | | | | | | | | | |  | | | | | | | | |  |  |  |
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|  |  |  |  |  |  | |  |  |  | | | | | | | | |  |  |  |
|  |  | |  | | --- | | I reviewed the Individualized Education Program (IEP) for this student and agree that the health-related services and evaluations recommended above by the IEP team are both appropriate and medically necessary. | | | | | | | | | | | | | | |  |
|  |  |  |  |  |  | |  |  |  | | | | | | | | |  |  |  |
|  | |  |  |  |  | | --- | --- | --- | --- | | **Authorized Signature:** |  | **\*Date of Signature:** |  | | **Practitioner’s Title:** |  | **License #:** |  | | **Face to Face Encounter** |  | **MA Provider #:** |  | | **with Student:** |  | **NPI #:** |  |   If review of medical necessity was conducted face-to-face with the student, separate documentation must be maintained.  **The date of signature is required prior to or on the date of service. Refer to section 4.8 of the SBAP Handbook for the definition of the date of service.** | | | | | | | | | | | | |  |