Medical Practitioner Authorization for SBAP Services

Student's Name: _____ **Date of the Current IEP Meeting:** _____

Participating School Name: _____

	Related Services	Frequency	Projected Start Date	Anticipated Duration	Group	Ind
_____	Audiology					
_____	Nursing					
_____	Occupational Therapy					
_____	Orientation & Mobility					
_____	Personal Care Assistant					
_____	Physical Therapy					
_____	Physician					
_____	Psychiatric					
_____	Psychological					
_____	Social Work					
_____	Speech/Language/Hearing					
_____	Teacher of the Hearing Impaired					
_____	Special Transportation					

Re-Evaluations to be provided throughout the duration of this IEP.

_____ **Re-Evaluations** _____ **Initial Evaluations**

_____ Audiology	_____ Occupational Therapy	_____ Orientation and Mobility
_____ Physical Therapy	_____ Psychiatric	_____ Psychological
_____ Social Work	_____ Speech/Language/Hearing	

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 with Student: _____ **MA Provider #:** _____

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.