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| Medical Practitioner Authorization for SBAP Services |

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| Occupational Therapy |

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| Orientation & Mobility |

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| Speech/Language/Hearing |

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| Teacher of the Hearing Impaired |

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| 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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| Occupational Therapy |

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| Orientation and Mobility |

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| Physical Therapy |

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| Social Work |

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| Speech/Language/Hearing |

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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. |

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| **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.**  |  |