FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

THERAPY SERVICES
REFERRAL/EVALUATION/PRESCRIPTION FORM
(Optional*)

REFER TO THE THERAPY SERVICES COVERAGE AND LIMITATIONS HANDBOOK FOR COMPLETE POLICY INFORMATION

Recipient Name: _____ **Medicaid ID #:** _____

Date Last Seen In Office: _____ **Primary Diagnosis/ICD-9:** _____

Referring Provider ID #:_____ **MediPass Authorization #:**_____
(If Required)

REFERRAL TYPE : (Check All That Apply) **PT** _____ **OT** _____ **SLP** _____ **RT** _____

CHECK ALL THAT APPLY:

☐ **PRESCRIPTION FOR EVALUATION**
(All therapy services must be prescribed by the recipient's PCP, an ARNP, designated PA or physician specialist.)

☐ **PRESCRIPTION FOR TREATMENT**

☐ **PRESCRIPTION FOR REAUTHORIZATION OF TREATMENT**
(The presciber must review the renewed plan of care at the end of the authorized period and can reauthorize services if medically necessary.)

Complete this box if this is a prescription for treatment or reathtorization of treatment.

Occupational Therapy (OT)
_____ Minutes Per Week
_____ Duration (wks/mos)
Y / N Medically Necessary**

Physical Therapy (PT)
_____ Minutes Per Week
_____ Duration (wks/mos)
Y / N Medically Necessary**

Speech Therapy (ST)
_____ Minutes Per Week
_____ Duration (wks/mos)
Y / N Medically Necessary**

Respiratory Therapy (RT)
_____ Minutes Per Week
_____ Duration (wks/mos)
Y / N Medically Necessary**

Other Information/Comments: _____

PCP Name (Please Print) _____ Other Authorized Prescriber (Please Print) _____

Signature _____ Date _____ Signature _____ Date _____

By signing as the PCP and/or other authorized provider, I hereby certify that if I am prescribing treatment, I have reviewed each element of the therapy plan of care, that the goals are reasonable and appropriate for this patient, and that if this prescription is for a continuing plan, I have reviewed the patient's progress and adjusted the plan of care goals if necessary.

*Please note this form is not required by Florida Medicaid to prescribe therapy services. This form is provided as an optional convenience to therapy providers to assist in the process of obtaining a prescription.

** By indicating yes to this item, the prescriber affirms that the services meet the definition of "medical necessity" outlined in the Medicaid Therapy Services Coverage and Limitations Handbook.