WRITTEN RECOMMENDATION FOR
MEDICAID REIMBURSABLE SCHOOL-BASED HEALTH SERVICES

STUDENT NAME: _____ DOB: _____

SCHOOL DISTRICT: _____

For and with the frequency and duration of the IEP/IFSP dated: _____

I have assessed the child's/student's status and recommend the following treatment to be included in the IEP/IFSP:

Speech Services

Signature: _____ Date: _____

Credentials: _____

Occupational Therapy

Signature: _____ Date: _____

Credentials: _____

Physical Therapy

Signature: _____ Date: _____

Credentials: _____

Nursing Services

Signature: _____ Date: _____

Credentials: _____

Psychological Services

Signature: _____ Date: _____

Credentials: _____

FEE FOR SERVICE BILLING DEPARTMENTS:

Central Oregon Regional Services	Ph: 541.693.5700	Fax: 541.693.5701
Bend LaPine School District	Ph: 541.383.6577	Fax: 541.383.6003
Redmond School District	Ph: 541.923.8265	Fax: 541.548.6097
Crook County School District	Ph: 541.416.9971	Fax: 541.416.9961

PURPOSE:
The purpose of this form is to meet SBHS rule 410-133-0160 and is used for Medicaid billing procedures only.
410-133-0160: Licensed Practioner Recommendation
Request for payment of medical services required by a child's IEP/IFSP must be supported by written recommendation from a physician or a licensed practioner of the healing arts within the scope of their practice. The recommendation must be updated annually.