ADAMS WELLS
SPECIAL SERVICES COOPERATIVE

Medicaid Referral
Speech-Language Therapy/Occupational Therapy

Student Name:_____ DOB:_____ STN:_____

Clinician/Therapist Name:_____ School Corporation:_____

Speech-Language
☐ Evaluation
☐ Treatment Services: _____
☐ Other: _____

Occupational Therapy
☐ Evaluation
☐ Treatment Services: _____
☐ Other: _____

Precautions: _____

_____

Additional Comments: _____

_____

Authorized Signature: _____

Print Name & Title: _____

National Provider Identifier (NPI) #: _____

Date: _____

Note: Visit NPPES NPI Registry to perform a search