RE: , DOB:

Dear :

We would like to inform you that your patient, ,
has been enrolled in Early Intervention at .
currently qualifies for our program based on
the criteria of

In order to provide services to our families in a timely manner, we request that you review, sign and return the attached Physician Authorization of Services (PAS), via fax or hardcopy, within ten days. If you have any questions or if you would like further information about the services being provided, please feel free to contact me. We look forward to working in partnership with you to best serve this child and family.

Regards,

phone:
fax:

PHYSICIAN AUTHORIZATION OF SERVICES

Client ID:
Client's Name:
Client Address:

Client DOB:

Service Coordinator:
EI Provider:
EI Address:

EI Phone:
EI Fax:

Early Intervention provides services designed to meet the functional, developmental outcomes that the family and EI team identify for the child.
A multidisciplinary team evaluation/assessment was done on:
The client is eligible for Early Intervention services due to:

Primary Diagnosis: ICD-10 Code:
Secondary Diagnosis: ICD-10 Code:
Tertiary Diagnosis: ICD-10 Code:

Areas of delay:

Cognitive
Expressive Communication
Receptive Communication
Fine Motor Skills
Gross Motor Skills
Social Emotional
Adaptive Skills
Health
Vision
Hearing
Family Circumstances

Authorization of Service From: To:
Physician's Name/Practice
Physician's Address:

THIS SECTION TO BE COMPLETED BY PHYSICIAN:
I certify/recertify that this patient needs early intervention services that may include: assistive technology, audiology, family training and counseling, health and nursing services, nutrition, occupational therapy, physical therapy, psychological services, service coordination, social work, special instruction, speech-language pathology, and vision services. This patient is under my care and I have authorized early intervention services as determined by the patient's parent(s)/guardian(s) and the EI team and will periodically review the plan.

Additional Physician's Comments:

Physician's Signature: _____ **Date:** _____

□ I would like a copy of my patient's Individualized Family Service Plan (IFSP)
□ I would like a written update on my patient's progress every 6 months.
□ I would like you to call me so we can further discuss my patient's needs.

PLEASE FAX BACK TO EARLY INTERVENTION AT **WITHIN TEN DAYS**