ELIM CHRISTIAN SCHOOL
OCCUPATIONAL THERAPY PRESCRIPTION FOR MEDICAID BILLING

The information on this form will remain in effect from the date of signing through August 31, 20_____.

Student _____ Birth date _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I give my permission for the release of therapy reports, medical and/or diagnostic information regarding my child from the below named physician.

Parent/guardian signature _____ Date _____

Address _____ Phone (____)_____

City _____ State _____ Zip _____

TO BE COMPLETED BY PHYSICIAN:

❑ Occupational Therapy Treatment, if necessary

Student's diagnosis_____

_____

Are there any precautions or contra-indications for this student? ❑ **Yes** ❑ **No**

If **yes,** please comment:

Physician's signature _____ Date _____

Physician's name (please print)_____

Address _____ Phone (____)_____

City _____ State _____ Zip _____

Please fax completed and signed form to Elim Christian School at 708-389-0671. Thank you.