



Enhanced Health Services
Fax (888-268-4124)

Prescription for Services

Name: _____ D.O.B.: _____ Date: _____

Expiration Date: 1 year

Diagnosis: (ICD 10 Code/s): _____

Duration & Frequency: _____ per week

Occupational Therapy

- EVAL & TREAT
- Therapeutic Exercise
- Therapeutic Activities
- Neuromuscular
Reeducation
- Sensory Integration
- Self-Care Training
- Manual Therapy

Physical Therapy

- EVAL & TREAT
- Therapeutic Exercise
- Therapeutic Activities
- Neuromuscular
Reeducation
- Manual Therapy
- Gait Training
- Orthotic management

Speech Therapy

- EVAL & TREAT
- Speech and Language
Delay
- Swallowing
- AAC
- Speech Sound Errors
- Other

DME _____

☐ I certify that the services indicated above are medically necessary.

Physician Signature

Date

Please print name :

Phone Number

Address