Recommendation For Children's Habilitation Intervention Services

Section #1: Individual's Information	
First Name:	Last Name:
Medicaid ID #:	Birthdate:
Email Address:	Phone Number:
Parent/Decision Making Authority Name:	
☐ I am the above listed individual's parent/decision making authority and I am giving consent to request a physician's recommendation for Children's Habilitation Intervention Services. Parent/Decision Making Authority Signature: _____ Date: _____	

Section #2: Submit Recommendation Form To	
Contact Person Name:	Phone Number:
Email Address:	Fax (if applicable):
Address:	

Section #3: Physician or Other Practitioner of the Healing Arts Information & Recommendation Section
Physician Name:
Phone Number:
☐ I agree with the recommendation for Children's Habilitation Intervention Services for the child listed above. ☐ I do not agree with the recommendation. Reason for disagreement: _____ _____ _____ Printed Name: _____ Signature and Credential: _____ Date: _____

This form should be returned to the submitting contact person listed in Section #2 of the form.