Medical Practitioner Authorization Form for SBAP Initial Evaluation Services

Student's Name: _____
Participating LEA Name: _____

Initial Evaluations

☐ Audiology	☐ Occupational Therapy	☐ Orientation, Mobility & Vision
☐ Physical Therapy	☐ Psychiatric	☐ Psychological
☐ Social Work	☐ Speech & Language	☐ Hearing Impaired

I agree that the Initial Evaluations above are both appropriate and medically necessary.

Authorized Signature _____ *Date of Signature _____

Printed Name/Practitioner Title _____ License # _____

NPI # _____ MA Provider ID # _____

If review of medical necessity was conducted face-to-face with the student, separate documentation must be maintained.

***The date of signature is required prior to or on the date of service. Refer to Section 4.8.d of the SBAP Handbook for the definition of the date of service.**