

B.74 THSteps-CCP ECI Request for Initial/Renewal Outpatient Therapy

Child's Name:		DOB:	Medicaid #:	
Has the child received therapy in the last year from the public school system? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Indicate the date of initial evaluation:	PT	OT	SLP	
Diagnoses:				
Requested Treatment Plan. Indicate the date(s) of service and frequency per week or month:				
	PT Service Date(s) FROM:	TO:	Frequency Per Week:	Per Month:
	OT Service Date(s) FROM:	TO:	Frequency Per Week:	Per Month:
	SLP Service Date(s) FROM:	TO:	Frequency Per Week:	Per Month:
New Application: Have treatment goals been developed? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is the child capable of making measurable progress? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Renewal Application: Has the child made measurable progress during this period? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is the child capable of making continued measurable progress during this period? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Provider's Name:				
Billing Address (Street or PO Box)		City	State	ZIP
Physician's Name: (Please Print)		Signature	TPI	Date
Therapist's Name (PT): (Please Print)		Signature	TPI	Date
Therapist's Name (OT): (Please Print)		Signature	TPI	Date
Therapist's Name (SLP): (Please Print)		Signature	TPI	Date