NYSS
NEW YORK SPEECH SOLUTIONS

SPEECH THERAPY PRESCRIPTION

Patient's Name: ______________________________ DOB: ______________

Patient's Address: ____

Patient's Phone: ____

Medicare Patient: Medical Benefit Traditional Part B: ☐ Yes ☐ No

Medicare #: ____

Secondary Insurance #: ____

Medical Precautions: ____

Frequency/Duration: ____

☐ EVALUATION & TREATMENT AS INDICATED

- ☐ Speech/Language Therapy
- ☐ Swallowing Therapy
- ☐ Voice Therapy
- ☐ Cognitive Rehabilitation
- ☐ Other: ____

Notes/Dx: ____

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I certify the above services are medically necessary for the patient's plan of care.

Healthcare Professional Name:______________________________________

UPIN #: _______________________ NPI #: ___________________________

Address: ____

Phone: ____

Healthcare Professional's Signature: ______________________________

Date: __________________________