Texas Medicaid Pediatric Supplement to the PSF–750
This form is required to be completed, signed and then included with the authorization request Required only for patients 20 years old or younger.

Patient Information

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Patient insurance ID#</th>
<th>Patient date of birth</th>
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</thead>
</table>

Referring Provider’s Name and Credentials on Plan of Care (POC) | Referral Date | Plan of Care Certification Date (Most Recent) | Current TX Health Steps (THSteps) Date |

Provider Information

Specialty or Service being requested (please select only one)

- OT
  - Occupational Therapy Contact: Name of the evaluating and/or treating occupational therapist and phone number.

- PT
  - Physical Therapy Contact: Name of the evaluating and/or treating physical therapist and phone number.

- ST
  - Speech Therapy Contact: Name of the evaluating and/or treating speech therapist and phone number.

Clinical Information and Tests

*Pediatric authorizations must include at least one Function Outcome Measure (FOM) or one of the following assessments

<table>
<thead>
<tr>
<th>Assessment Tool* or Instrument (if Other—Please list)</th>
<th>Evaluation Date:</th>
<th>Retest 1 Date:</th>
<th>Retest 2 Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other:</td>
<td>Standard (Raw) Score</td>
<td>Standard Dev (SD) or Percentile</td>
<td>Standard (Raw) Score</td>
</tr>
</tbody>
</table>

2. Other:

- Peabody: PDMS-2©
- BOT, 2nd Edition (BOT™-2)
- Beery™ VMI
- CELF®
- GFTA™

Functional/Measurable Goals

<table>
<thead>
<tr>
<th>Functional/Measurable Goals</th>
<th>Current Status</th>
<th>Previous Status</th>
<th>Functional Relevance/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<td>2.</td>
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<td>3.</td>
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</tbody>
</table>

Treatment Intensity and Frequency Requested: __________visits per (week / month) for __________weeks/months

(IIndicate # of visits) (Circle) (Indicate duration)

Treatment plan/Plan of Care (POC) as related to above goals (must include rationale for frequency and intensity)

1.  
2.  
3.  

1.  
2.  
3.  

Required Signatures

Therapist: X Date: 

By signing this form; the provider (therapist) attests that the client's medical record includes a comprehensive therapy Plan of Care (POC) and the POC contains all Texas Medicaid required elements; and that the POC has also been signed and dated by the client’s PCP. This signature also attests that the provider (therapist) has discussed, and reviewed the intended treatment plan with the Parent/Guardian and they are in full agreement with the proposed treatment plan.

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Peds Sup to PSF-750
Version: 4/26/2018