

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

Patient name: Last	First	MI	Patient insurance ID#	Patient date of birth
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

1. 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.

Has the client received therapy in the last year from the public school system? Yes No If yes, date of current IEP: _____

Place of Service Requested (please check one of the following):

Office (11) Home (12) Hosp Out Patient (22) NF/SNF (31/32) CORF/ORF (62) Other: (specify _____)

Clinical Information and Tests

(Please fill in selections completely)

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

Assessment Tool* or Instrument (if Other—Please list)	Evaluation Date:		Retest 1 Date:		Retest 2 Date:	
	Standard (Raw) Score	Standard Dev (SD) or Percentile	Standard (Raw) Score	Standard Dev (SD) or Percentile	Standard (Raw) Score	Standard Dev (SD) or Percentile
Other:						
Other:						
Peabody: PDMS-2©						
BOT, 2nd Edition (BOT™-2)						
Beery™ VMI						
CELF®						
GFTA™						

Functional/Measurable Goals	Current Status	Previous Status	Functional Relevance/ Comments
1.			
2.			
3.			

3. Treatment Intensity and Frequency Requested: _____ visits per (week / month) for _____ weeks/months
(Indicate # 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. _____

Required Signatures

4. 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.