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**

2.

	Evaluation Date:		Retest 1 Date:		Retest 2 Date:	
Assessment Tool* or Instrument (if Other—Please list)	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.