Medical Practitioner Authorization Form for SBAP Services

Student's Name: _____ Date of the current IEP Meeting: _____
Participating LEA Name: _____ (MM/DD/YY)

Related Service	Duration	Frequency	Projected Start Date	Projected End Date	Group	Individual
Audiology					N/A	
Nursing					N/A	
Occupational Therapy						
Occupational Therapy						
Orientation, Mobility & Vision					N/A	
Personal Care Services					N/A	
Physical Therapy						
Physical Therapy						
Psychiatric						
Psychiatric						
Psychological						
Psychological						
Social Work						
Social Work						
Speech & Language						
Speech & Language						
Hearing Impaired						
Hearing Impaired						
Special Transportation					N/A	

Re-Evaluations to be provided throughout the duration of this IEP:

☐ Audiology ☐ Occupational Therapy ☐ Orientation, Mobility & Vision
☐ Physical Therapy ☐ Psychiatric ☐ Psychological
☐ Social Work ☐ Speech & Language ☐ Hearing Impaired

I have reviewed the Individualized Education Program (IEP) for this student and agree that the health-related services and re-evaluations recommended above by the IEP team are both appropriate and medically necessary.

Authorized Signature _____ *Date of Signature _____

Printed Name/Practitioner Title _____ License # _____

NPI # _____ MA Provider ID # _____

If review of medical necessity was conducted face-to-face with the student, separate documentation must be maintained.

***The date of signature is required prior to or on the date of service.**

Pennsylvania Department of Human Services
Revised 07/12/2023
Email: RA-PWSBAP@pa.gov