UF Department of Pediatrics College of Medicine UNIVERSITY of FLORIDA

NCES Therapy Treatment Plan

early steps North Central

Florida HEALTH Children's Medical Services

Child Information:			
Name:	DOB:	Age:	Gender:
Mailing Address, City, State Zip Code:	Medicaid #:		ESID#:

Therapist Information:		
Name:	NPI:	State License #:
Address:	Phone:	Fax:

Early Steps Information:			
Eligibility Date:	IFSP Date:	Authorization Period:	Service Coordinator:

Medical Information:	
Diagnostic Code(s):	Description(s):
Brief Medical History:	

Evaluation Report:		
Date of Evaluation:	Test(s) Administered:	Scores:
Assessment (including functional limitations):		

Progress Toward Goals from Previous Plan of Care:

Outcomes and Goals:
Functional Outcome(s) Identified at Evaluation:
Functional Short-Term Goal(s):

NCES Therapy Treatment Plan

Therapeutic Methods and Monitoring Criteria:

Caregiver Education:

Coordination of Treatment with Other Services:

Plan of Care:			
Procedure Code:		**Service Frequency:**	
Service Length:		**Service Location:**	
POC Start Date:		**POC End Date:**	

Medical Necessity Criteria:	
Necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain.	☐
Individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in the excess of the patient's needs.	☐
Consistent with generally accepted professional medical standards as determined by the Medicaid program, not experimental or investigational.	☐
Reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.	☐
Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.	☐

Treating Provider Signature:	
Printed Name and Credential:	**Date**

Prescribing Provider Signature:	
As this child's attending physician, I agree with the PLAN OF CARE and deem therapy MEDICALLY NCESSARY. This PLAN OF CARE serves as the medical prescription for treatment.	
Prescriber's Signature:	**Date:**
Printed Name:	**Office Telephone:**
Prescriber's NPI:	**Office Fax:**