south dakota BIRTH TO THREE
The first three years build a lifetime

Request for Primary Care Physician Approval of the Birth to Three Program Individual Family Service Plan (IFSP)

Child's Name_____

Date of Birth _____/_____/_____ **Medicaid #**_____

Parent's Name_____ **Telephone #:** _____

Parent's Address_____ **City**_____**ZIP**_____

Physician's Name_____ **Clinic**_____

This Authorization is Valid _____ **to** _____

To be completed by physician

☐ I **approve** the services as prescribed in the Individual Family Service Plan (IFSP) for (child's name)_____, for a period of one year or when the child exits the program, whichever occurs first.

☐ I **do not approve** the services as prescribed in the Individual Family Service Plan (IFSP) for (child's name)_____, for a period of one year or when the child exits the program, whichever occurs first.

Comments:

_____ _____ _____

Primary Care Physician's Signature ***NPI#*** ***Date***

Note to Primary Care Physician: If you have questions or concerns regarding the IFSP, please contact the Birth to Three Service Provider.

_____ _____

Birth to Three Service Provider's Name ***Telephone Number***

Please fax this completed form back to the Service Provider at _____