



**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 _____

I give permission to my child's Primary Care Physician to contact my child's Birth to Three Service Coordinator.

Parent's Signature

Date

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 child's parent, or the Birth to Three Service Coordinator assigned to this child.

Birth to Three Service Coordinator's Name

Telephone Number

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