Summit Sprouts Therapy, LLC.

Mobile Outpatient and Virtual OT Services

Patient Name:_____ DOB:_____

Insurance:_____ Insurance #:_____

Contact Name:_____ Phone:_____

Commonly Used ICD-10 Codes

•	F82-SPECIFIC DEVELOPMENTAL DISORDER OF MOTOR FUNCTION
•	F909-ATTENTION-DEFICIT HYPERACTIVITY DISORDER, UNSPECIFIED TYPE
•	F84-PERVASIVE DEVELOPMENTAL DISORDERS
•	F840-AUTISTIC DISORDER
•	R27-OTHER LACK OF COORDINATION
•	M6281-MUSCLE WEAKNESS (GENERALIZED)
•	M256-STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED
•	Other:

Conditions Commonly Associated with Treatment of Pediatric Patients

•	R62-LACK OF EXPECTED NORMAL PHYSIOL DEV IN CHILDHOOD AND ADULTS
•	R620-DELAYED MILESTONE IN CHILDHOOD
•	R625-OTH AND UNSP LACK OF EXPECTED NORMAL PHYSIOL DEV IN CHLDHD
•	R6251-FAILURE TO THRIVE (CHILD)
•	R633-FEEDING DIFFICULTIES
•	Other:

Physician Signature & Referral

____ OT Evaluation / Treatment for ____ (#) sessions. OT Evaluation Only ____

Physician's Signature:_____ Date:_____

Physician's Printed Name:_____ NPI#:_____

When signed by a physician, this form acts as a prescription for therapy services. Please return this form along with any additional relevant medical information to Summit Sprouts Therapy, LLC.