2300 130th Ave NE #102, Bellevue, WA 98005 | 425-590-9269 | www.ThrivePediatricClinic.com

Dear Physician:

Your patient _____ is seeking occupational therapy services with us.

Although occupational therapists outside of a hospital are not required to work under a physician's referral, insurance companies often require documentation of a physician's referral for consideration of reimbursement. The state of WA is a limited direct access state for OT services. Meaning you DO NOT need a referral to see an OT for an evaluation (e.g first appointment). In order to facilitate processing of insurance claims, a physician's referral with diagnosis is highly recommended.

In the absence of other diagnoses, the following may best describe the difficulties experienced by many of the children seen in our clinic:

M62.81 Muscle Weakness (Generalized)
R13.10 Dysgraphia
G70.2 Congenital and/or Developmental Myasthenia or
F82 Specific Developmental Disorder of Motor Function If the child has adequate coordination but has suspected sensory issues, some physicians use the diagnosis
F93.9 Childhood Emotional Disorder, Unspecified or
G96.9 Disorder of Central Nervous System, unspecified

Given a release of information, we would be happy to speak with you if there are questions about a diagnosis or our services.

Please fill out the attached, accompanying form and mail it to the address below, fax to **Fax Number # (844) 441-1839 Direct Number #(425) 590-9269** or email to admin@thrivepediatricclinc.com. Thank you for your support of this child and family.

2300 130th Ave NE #102, Bellevue, WA 98005 | 425-590-9269 | www.ThrivePediatricClinic.com

REFERRAL FOR PEDIATRIC OCCUPATIONAL THERAPY

Child's name: _____

Date of Birth:_____

CHECK ONE: once a week _____ twice a week_____

If more than one diagnosis is used please indicate primary with an *

____ M 62.81 Muscle Weakness (Generalized)
____R13.10 Dysgraphia
____ G70.2 Congenital and/or Developmental Myasthenia
____ F82 Specific Developmental Disorder of Motor Function
___ R29.3 Abnormal Posture, Head Position
___ G80 Cerebral Palsy; specify type: _____
___ G96.9 Disorder of Nervous System, Unspecified
___ R63.3 Feeding Difficulties, Oral Aversion
___ F50.9 Eating Disorder, Unspecified
___ F51.01 Primary Insomnia, Difficulty Initiating or Maintaining Sleep
___ F84.9 Pervasive Developmental Disorder, Unspecified
___ F84.0 Autism Spectrum
___F90.2 Attention Deficit Hyperactivity Disorder
___F84.2 Rett Syndrome
___ Q99.2 Fragile X Syndrome
___ Q90.9 Down Syndrome, Unspecified
___ F41.1 Generalized Anxiety Disorder;
___F41.9 Anxiety, Unspecified;
___ F40.8 Other Phobic Anxiety Disorders
___ F93.9 Childhood Emotional Disorder, Unspecified
___ R45.89 Emotional Dysregulation
___ Other: _____ (specify)

Physician name_____Address_____License Number_____

I verify that the services requested are medically necessary for the above-named patient.

Signature: _____ Date: _____

NPI#_____

Please submit this form via the following:

Fax Number # (844) 441-1839 or email to **admin@thrivepediatricclinc.com**.