

**Ohio Department of Health
Request for Payment of Additional Early Intervention Services**

Bureau of Early Intervention Services, 246 North High Street, Columbus, Ohio 43215 Fax (614) 728-9163

PLEASE PRINT

***DATA REQUIRED IN ORDER TO PROCESS**

*Child's name (last, first, middle)				Letter of Approval Case Number: -			
*Address				*County			
*City			*State		*ZIP		
*Child's birthdate		Social Security number (child's)		*Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		*Ethnic group	Ohio resident Yes <input type="checkbox"/> No <input type="checkbox"/>
*Parent's/Legal guardian's name (last, first)				*Parent's/Legal guardian's name (last, first)			
*Address				*Address			
*City		*State	*ZIP	*City		*State	*ZIP
Social Security number				Social Security number			
*Home phone ()		*Work phone ()		*Home phone ()		*Work phone ()	

ADDITIONAL SERVICES/ UNITS REQUESTED

*Category of service	*Name and address of provider	*Frequency	*Source of payment

Note: Please attach evaluations, recommendations and assessments, section VI and VII of the IFSP

*Service coordinator's signature			*Date		
*Service coordinator's name (PRINT)			*Agency name		
*Address				Telephone number ()	
*City			*State	*ZIP	
*Primary diagnosis		I.C.D. code	*Secondary diagnosis		I.C.D. code
Name of primary care physician			Name of primary care dentist		