[letterhead, include address and phone number]

Date
Address of Medi-Cal Plan

To Whom It May Concern:

I am writing on behalf of my patient, _____ (DOB _____, Medi-Cal # _____). S/He has been a patient of mine since _____. _____is a _____ year old boy(girl) who presents with autistic disorder. I made this diagnosis in _____ (year). (or Dr _____ made this diagnosis in _____(year). _____'s autism results in (moderate to severe) impairments in general functioning.

(If new therapy is needed):
_____ needs evaluations for speech therapy, occupational therapy, and ABA therapy (choose any or all), and therapy in the amount determined by the evaluation. These services are medically necessary to prevent further deterioration of function and allow _____ to function at his/her maximal level of ability.

(If continued therapy is needed):
_____ needs continued therapy for speech therapy, occupational therapy and ABA therapy (choose any or all). These services are medically necessary to prevent further deterioration of function and allow _____ to function at his/her maximal level of ability.

These interventions are medical, not educational, and facilitate functioning in home and community settings. _____ has an individualized educational plan (IEP) which attempts to address some of the educational aspects of his/her autism.

I will continue to monitor and oversee _____'s progress.

Please contact me if you have any further questions.
Sincerely,

Dr _____

License #