



Utilization Management
Phone No.: 1-877-284-0102 Fax No.: 1-800-510-2162

Speech Therapy Pre-Review

Date: _____ Notification # _____ (provided after initial review)
A Utilization Management representative will fax you a notification number by the next business day after receiving this completed form. This notification number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care department. If you have any questions, please call Healthlink at 1-877-284-0102.

A copy of the physician's order for services and a copy of the initial evaluation are required prior to review of the requests of initial and ongoing services.

Provider Information

Provider's Name _____
Address _____
Phone No. _____ Fax No.(Required) _____

Patient Information

Patient's Name: _____ Patient's DOB: _____
ID Number _____ Daytime Phone No. _____
Address _____

Ordering Physician Information

Physician's Name: _____
Address _____
Phone No. _____ Fax No. _____
TIN: _____ Doctor's script on file YES NO

Treatment Information

Diagnosis: Primary _____ Secondary _____

Reason for speech therapy (Congenital abnormality, illness, injury, or surgical) _____

If so, please explain (date of onset and condition) _____

Does member have autism YES NO

Are the speech therapy visits being performed in the home or outpatient facility _____
If they are being performed in the home, is this member homebound _____

START DATE: _____ Height: _____ Weight: _____

ANTICIPATED DISCHARGE DATE: _____

Request: No. of visits: # _____ from _____ through _____

The evaluation and progress updates should contain the following information

Initial Evaluation

Functional level prior to current illness: _____

Tests performed to assess communication and/or swallowing: _____

Analytic interpretation of test results along with summary of baseline findings: _____

Objective measurable descriptions of individuals deficits: _____

Plan of Care: _____

Measurable short term goals: _____

Measureable long term goals: _____

Rehabilitation Prognosis _____

Progress Re-evaluation

Functional level prior to current illness: _____

Tests performed to assess communication and/or swallowing: _____

Analytic interpretation of test results: _____

Objective measurable descriptions of individuals deficits: _____

Plan of Care: _____

Measurable short term goals: _____

Measureable long term goals: _____

Rehabilitation Prognosis _____

Contact Information

Contact Person _____

Phone No. _____ Fax No. _____

Staff Signature/Title: _____ Date: _____

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.