



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

**Speech Therapy Progress Evaluation Recertification Review**

Date: \_\_\_\_\_ Reference #: \_\_\_\_\_ (provided after initial review)  
*A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference 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 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_  
 ID Number: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Patient DOB: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**Ordering Physician Information**

Physician Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 TIN: \_\_\_\_\_

**Progress Re-evaluation**

Is the doctor script/order on file?     YES     NO  
 Start Date for Extension: \_\_\_\_\_  
 Anticipated End Date for Extension: \_\_\_\_\_  
 Number of Visits: \_\_\_\_\_  
 Is the Diagnosis and Reason for speech therapy the same?     YES     NO  
 What was the functional level prior to current illness? \_\_\_\_\_  
 What tests were performed to assess communication and/or swallowing? \_\_\_\_\_  
 \_\_\_\_\_  
 What are the test results and summary of baseline findings? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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.

Please provide, if any, objective descriptions of individual's deficits: \_\_\_\_\_

Plan of Care: \_\_\_\_\_

Short-Term Goals:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Long-Term Goals:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Rehabilitation Prognosis: \_\_\_\_\_

**Provider Contact Information**

Contact Person: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_