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

Speech Therapy Initial Precertification 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 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: _____

Patient DOB: _____

Address:_____

ID Number:_____

Phone:_____

Ordering Physician Information

Physician Name: _____

Address:_____

Phone:_____

Fax:_____

TIN: _____

Treatment Information

Is the doctor script/order on file? ☐ YES ☐ NO

Primary Diagnosis: _____

Diagnosis (ICD-10) Code: _____

Primary Procedure: _____

Primary Procedure (CPT) Code: _____

Reason for speech therapy (Congenital abnormality, illness, injury, or surgical), please explain date of onset and condition: _____

_____

Does member have autism? ☐ YES ☐ NO

What setting is speech therapy visits being performed? ☐ Home ☐ Outpatient

If services are being performed in the home, is the patient homebound? ☐ YES ☐ NO

Start Date: _____

Anticipated End 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.

Number of Visits: _____

Frequency of Visits: _____

Initial Evaluation

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? _____

_____

_____

Please provide, if any, objective descriptions of patient's deficits: _____

_____

_____

Do the services require the judgment, knowledge and skills of a qualified provider of speech therapy services due to complexity and sophistication of the therapy and the medical condition of the individual? ☐ YES ☐ NO

Are the services being delivered by a qualified provider of speech therapy services? ☐ YES ☐ NO

A qualified provider is one who is licensed, where required, or holds the Certificate of Clinical Competence (CCC) granted by the American Speech-Language-Hearing Association (ASHA), and performs within the scope of licensure.

Anticipated Treatment Plan: _____

_____

_____

Short-Term Goals:

1. _____
2. _____
3. _____

Long-Term Goals:

1. _____
2. _____
3. _____

Rehabilitation Prognosis: _____

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____