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:_____