Prior Authorization Form

Speech Therapy

Patient's Name: ______________________ DOB: __________ ID#________________

Ordering Physician:______________________ Clinic: ______________________

Therapy Provider: ______________________ Tax ID: __________ NPI: ______________
Name/Specialty/Clinic

Phone: ______________________ Fax: ______________________

Diagnosis:______________________ ICD-10:__________ Date of Initial Eval: __________

Is this a Worker's Comp or accident case? ☐ Yes ☐ No

Dates of service requested: ____

Number of visits requested: ____

PLEASE SEND EVALUATION FOR FIRST REQUEST ONLY. ADDITIONAL REQUESTS WILL NEED ONLY THE MOST RECENT VISIT NOTE. THERAPY REQUESTS MUST INCLUDE THE ENTIRE SCORING SCALE INCLUDING THE STANDARD SCORES AND THE MEMBER'S SCORE.

Provider Contact Name	Phone #	Fax #	Date

A Speech Therapy Request Form will be required after the initial evaluation. If additional visits are needed, authorization is required prior to continuing. Services must be prescribed by a Physician to be considered a covered benefit.

Privacy and Confidentiality:
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