

HEALTHCHOICE

3545 NW 58th, Suite 500, Oklahoma City, OK 73112
Phone: 1-800-543-6044 or 1-405-717-8879
FAX: 1-405-717-8947 or 1-405-717-8935

SPEECH THERAPY REQUEST

This information is private and confidential.

(◆) Billing Provider: _____ (◆) Date: _____
(◆) Billing Address: _____
(◆) TIN: _____ Contact Person : _____
Phone: _____ (◆) Fax # : _____
(◆) Referring Physician : _____ (◆) Diagnosis : _____
(◆) Patient: _____ (◆) DOB: _____
(◆) Member (if other than patient): _____ (◆) Member ID #: _____
(◆) Communicative Diagnosis: _____ (◆) Date of onset: _____
(◆) Medical Diagnosis _____

Summary Progress Towards Current ST Goals: _____

New ST Goals: _____

TREATMENTS

CERT MET / PENALTY APPLIES

Evaluation Dates Initial Evaluation: _____ 1st Evaluation: _____
2nd Evaluation: _____
Total Treatments to Date: _____ 3rd Evaluation: _____
Request for Additional Treatments: _____ # of Treatments: _____
Frequency of Treatments: _____
Dates for Additional Treatments Beginning Date: _____ Ending Date: _____

*****FOR HEALTHCHOICE USE ONLY (Do Not Write Below This Line)*****

CERT MET / PENALTY APPLIES

Extension #1 -- # of Treatments Approved: _____ Start Date: _____ Ending Date: _____
Approved By: _____ Date: _____

CERT MET / PENALTY APPLIES

Extension #2 -- # of Treatments Approved: _____ Start Date: _____ Ending Date: _____
Approved By: _____ Date: _____

NOTE: These benefits are applicable only if the patient is eligible for HealthChoice, and are subject to ALL POLICY PROVISIONS. Please remember to verify benefits and eligibility by calling 1 (800) 782-5218.

MEDICARE PATIENTS: If HealthChoice is supplement, all services requested must initially be approved by Medicare.

(◆) **DENOTES INFORMATION REQUIRED TO COMPLETE REVIEW FOR CERTIFICATION**