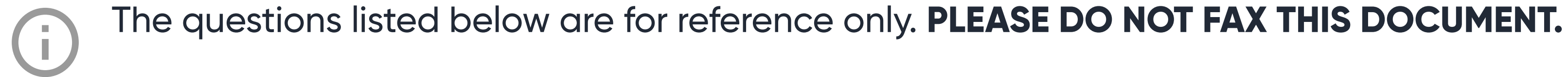
Speech Therapy (Outpatient Only)



The questions listed below are for reference only. **PLEASE DO NOT FAX THIS DOCUMENT.**

Patient Information

First name	Last name

Member ID	Date of birth (MM/DD/YYYY)

Special Note

A max of 8 visits may be eligible for auto-approval on initial speech therapy requests on this single service.

Question 1

Have any of the following findings been documented in a recent encounter? (Required, fill in all that apply)

- ☐ Documentation of any speech delay or speech disorder
- ☐ Difficulty swallowing
- ☐ Difficulty chewing food
- ☐ Cognitive impairment
- ☐ None of the above

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