HealthChoice
3545 N.W. 58th St., Ste. 600, Oklahoma City, OK 73112
Phone: 405-717-8879 or 800-543-6044, ext. 8879
Fax: 405-949-5459 or 405-949-5501

SPEECH THERAPY REQUEST

This form must be completed and accompany all requests. Incomplete forms will not be reviewed.

Billing Provider: _____ Date: _____

Billing Address: _____

TIN: _____ Contact Person: _____

Phone: _____ Fax: _____

Referring Physician: _____

Patient: _____ DOB: _____

Member: _____ Member ID: _____

Communicative Diagnosis ICD 10 Code: _____ Date of Onset: _____

OR

Autism Spectrum Disorder ICD 10 Diagnosis Code: _____ Date Diagnosed: _____

Name of MD, DO or Doctor of Psychology diagnosing Autism Spectrum Disorder: _____

CPT Code(s): _____

Summary Progress Toward Current ST Goals: _____

New ST Goals: _____

TREATMENTS

Initial Evaluation Date: _____ Total Treatments to Date: _____

2nd Evaluation Date: _____ 3rd Evaluation Date: _____

Request for Additional Treatments

Number of Treatments: _____ Frequency of Treatments: _____

Dates for Additional Treatments – Beginning Date: _____ Ending Date: _____

**** All information is required for review. Information provided is private and confidential. ****

NOTE: These benefits are applicable only if the patient is an eligible enrolled member of a HealthChoice plan. All benefits are subject to the deductible, coinsurance and policy provisions. Please verify benefits and eligibility by calling the medical claims administrator toll-free at 800-323-4314.

MEDICARE PATIENTS: If HealthChoice is the supplemental insurance carrier, authorization from HealthChoice is not required. Please contact Medicare.