



Speech Therapy Questionnaire

Please return the completed form and all required documentation to:

Medical Review Department

P.O. Box 1999

Studio City, Ca 91614-0999

Or by email to: MedicalReview@mpiphp.org

In order to have enough information for the Plan's staff to determine coverage, please send back the following:

- Completed Speech Therapy questionnaire signed by the treating Speech Language Pathologist
- A copy of the Speech Therapy Evaluation explaining the need for speech therapy
- Prescription from the referring physician (MD, DO, or NP) with diagnosis
- Audiology report, if available

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|---|--|
| 1) Patient Name:
Participant Name: | DOB:
MPID: |
| 2) Name of Referring Physician:
Address: | Phone: |
| 3) Evaluation date(s): | |
| 4) Name of Speech Pathologist:
Address:
Fax: | NPI #:
Phone:
Tax ID# |
| 5) CPT Codes: | |

A maximum of 32 speech therapy visits are covered per calendar year if ordered by a treating physician, DO or NP. The initial visit/evaluation is allowed separately and is not included in the 32 treatment limitation.

Benefits for Speech Therapy are available ONLY for the diagnosis and guidelines listed below when rendered by a licensed Speech Pathologist:

For Participants and Dependents of all ages:

Stroke or other neurologic disease

Injury or surgery affecting speech or swallowing

For Dependent Children Age 16 Years and Younger:

Developmental speech delay

Autism

Dysarthria

Stuttering

Apraxia

Signature of Licensed Speech Pathologist: _____

License #: _____ **Date:** _____