Speech Therapy Questionnaire

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

1) Patient Name: DOB:
   Participant Name: MPID:

2) Name of Referring Physician: Phone:
   Address:

3) Evaluation date(s):

4) Name of Speech Pathologist: License #:
   Address: Phone:
   Fax:

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: Date

Please return the completed form and all required documentation to:
Medical Review Department
P.O. Box 1999
Studio City, Ca 91614-0999

Or by Fax to: 818-766-6532

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