Speech Therapy Visit Report

Speech therapists are to complete this form and fax it to Univera Healthcare when initial treatment visits are requested, and when additional visits are necessary.

Univera Healthcare Fax: (716) 857-6361 or 1 (888) 465-1373 Univera Community Health Fax: 1 (888) 273-8296
Questions: (Univera Healthcare) (716) 857-6303 or 1(888) 576-7783; Univera Community Health 1 (888) 638-7149

Patient / Member Information			
Member Name :		Member ID No.	
Member Age:	Member DOB:	Plan *(select one)*: o WNY o CNY o Univ. at Buffalo	
Diagnosis:		ICD-9 Code:	
Check as applicable: o Medicare Primary o Worker's Comp o No-Fault		Date of Injury:	
Date of Evaluation:	Date of Anticipated First Visit:	Date of Surgery (if applicable):	
Name of Requesting Physician:			

Speech Therapist (ST) Information	
ST Facility:	ST Provider ID#:
ST Phone:	ST Fax:

Progress Summary

Include severity of delay, % accuracy, age-level equivalencies, degree of change, etc. Also include % improvement from last request.

Attach Typed Initial Evaluation or Progress Notes

Provider Signature:	Date:	# Visits Used to Date:

Utilization Review *(for Univera Use Only)*

Criteria Met? o Yes o No *(If no, complete Reviewer Rationale)*		Reviewer Rationale:	
# Additional Visits Authorized:	Total # Visits Authorized:	o Per Member's Contract :	o Coverage Limited to 2 months per condition o Coverage limited to _____ days per year
Effective Referral Period:		o Insufficient information to justify request. Please submit:	o Initial evaluation o All typed progress notes o Summary of improvement over last 2 to 3-week interval o Updated physician script
Determined: o Based on objective data provided Date: _____		o Referred for medical review	

Authorization does not guarantee or confirm that benefits will be paid.
Payment of claims is subject to member eligibility and to contract limitations, provisions, and exclusions.