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.

Fax: (716) 857-6361 or 1 (888) 465-1373 **Questions: (716) 857-6303 or 1(888) 576-7783**

Patient / Member Information			
Member Name :		Member ID No.	
Member Age:	Member DOB:	Plan *(select one)*: ❑ WNY ❑ CNY ❑ Univ. at Buffalo	
Diagnosis:		ICD-9 Code:	
Check as applicable: ❑ Medicare Primary ❑ Worker's Comp ❑ 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? ❑ Yes ❑ No (*If no, complete Reviewer Rationale)*		Reviewer Rationale:
# Additional Visits Authorized:	Total # Visits Authorized:	❑ Per Member's Contract : ❑ Coverage Limited to 2 months per condition ❑ Coverage limited to _____ days per year
Effective Referral Period:		❑ Insufficient information to justify request. Please submit: ❑ Initial evaluation ❑ All typed progress notes ❑ Summary of improvement over last 2 to 3-week interval ❑ Updated physician script
Determined: ❑ Based on objective data provided Date: _____		❑ 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.