MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS™

# Speech Therapy Questionnaire
(Provider)

*Must be completed by a Licensed Speech Language Pathologist*

**Participant:** _____ **MPI ID:** _____

**Patient:** _____ **Date:** _____

**Benefits for Speech Therapy are available only for the diagnoses and guidelines listed below when rendered by a licensed Speech Language Pathologist:**

**For Participants and Dependents of All Ages (only** when prescribed within 90 days of the event):

- Stroke
- Injury or Surgery affecting speech

**For Dependent Children Age 16 Years and Younger:**

- Developmental Speech Delay
- Stuttering
- Autism
- Apraxia
- Dysarthria

In order to have enough information for the Plan's reviewing consultant to determine coverage, it is strongly recommended that this form be completed and signed by the treating licensed Speech Language Pathologist and submitted to the Medical Review Department with any relevant documentation. *(Please attach a separate sheet if additional space is needed.)*

1) **Name of referring physician:** _____ **Phone:**_____

   **Address:** _____

2) **Evaluation date(s):** _____

3) **Please submit a copy of your initial speech therapy evaluation report, and/or current progress report along with an audiology report, if available.**

4) **Speech/Language and related diagnoses:**

   **DX** _____ **ICD-10** _____

   **DX** _____ **ICD-10** _____

   **DX** _____ **ICD-10** _____

   **DX** _____ **ICD-10** _____

Patient's Name: _____

**5) Related/underlying medical/surgical factors:** _____

_____

_____

**6) Prognosis(es). Please state expected outcome(s) and when it/they will be achieved:**

_____

_____

**7) Goals and objectives. Please indicate goal(s) and related objective (s) for each area of focus in your treatment.**

Goal: _____

Objective: _____

Objective: _____

Goal: _____

Objective: _____

Objective: _____

**8) Please state your overall treatment plan for this patient, including frequency, intensity, modalities, coordination of services and report/re-evaluation timelines.**

_____

_____

**9) Please provide any additional information that will assist in this review and authorization.**

_____

_____

**Provider Name:** _____ **License #** _____
*(Licensed Speech Pathologist)*

**Address:** _____

**Telephone:** _____ **FAX:** _____

_____
**Signature of Licensed Speech Pathologist** **Date**

***Please return the completed form and any additional documentation to:***

Medical Review Department
P.O. Box 1999, Studio City, CA 91614-0999
or by FAX to: 818.766.6532