



PRIOR AUTHORIZATION for COGNITIVE, SPEECH, and VOICE THERAPY

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Name (Last, First MI):	DOB:	Age:	PEHP ID #:
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Section II: PROVIDER INFORMATION

Date Requested:		Service Provider Name:	
Service Provider NPI #:	Service Provider Tax ID #:	Service Provider Address:	
Contact Person:	Phone: ()	Facsimile: ()	

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: <i>Please check.</i> <input type="checkbox"/> Auth Extension <input type="checkbox"/> Pre-Auth <input type="checkbox"/> Retro Auth <input type="checkbox"/> Urgent	Requested Authorization Period:
Number of visits used in lifetime:	Number of visits being requested:
Primary Medical Diagnosis/ICD-10 Code:	Secondary Medical Diagnosis/ICD-10 Code:
Primary Treatment Diagnosis/ICD-10 Code:	Secondary Treatment Diagnosis/ICD-10 Code:

Service (s) Requested:

Service: _____	CPT/HCPCS code: _____	<input type="checkbox"/> Continued Therapy <input type="checkbox"/> Initial Request <input type="checkbox"/> Maintenance Therapy
Service: _____	CPT/HCPCS code: _____	<input type="checkbox"/> Continued Therapy <input type="checkbox"/> Initial Request <input type="checkbox"/> Maintenance Therapy
Service: _____	CPT/HCPCS code: _____	<input type="checkbox"/> Continued Therapy <input type="checkbox"/> Initial Request <input type="checkbox"/> Maintenance Therapy

(Please check service being requested.) QUESTION	YES	NO	COMMENTS/NOTES
A. <input type="checkbox"/> Cognitive Therapy: 1. Is cognitive therapy being ordered for any of the following? <i>Please check all that apply.</i> <input type="checkbox"/> Brain injury due to stroke, aneurysm, anoxia, encephalitis, brain tumor, or brain toxins <input type="checkbox"/> Moderate to severe traumatic brain injury/TBI <input type="checkbox"/> Stroke/Cerebral Infarction	<input type="checkbox"/>	<input type="checkbox"/>	
1. a. Does the patient have a compromised functional status related to the cognitive impairment?	<input type="checkbox"/>	<input type="checkbox"/>	
1. b. Is a significant cognitive improvement with improved related functional status expected?	<input type="checkbox"/>	<input type="checkbox"/>	
1. c. Is the patient willing and able to actively participate in the program (e.g. unresponsive)?	<input type="checkbox"/>	<input type="checkbox"/>	
1. d. Does the treatment regimen include specific interventions for functional communication deficits, including pragmatic conversational skills?	<input type="checkbox"/>	<input type="checkbox"/>	
1. e. Does the treatment regimen include compensatory memory strategy training?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is cognitive therapy being ordered to improve academic or work performance?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is cognitive therapy being ordered for any of the following conditions? <i>Please check all that apply.</i> <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Attention Deficit Disorder/ADD <input type="checkbox"/> Attention Deficit Hyperactivity Disorder/ADHD <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Dementia <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Human Immunodeficiency Virus (HIV) Dementia <input type="checkbox"/> Learning Disability <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Mild (Traumatic Brain Injury (TBI), including concussion and post-concussion syndrome. <input type="checkbox"/> Pervasive Developmental Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Wernicke Encephalopathy	<input type="checkbox"/>	<input type="checkbox"/>	

**Speech & Voice Therapy: see page 2*

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Name (Last, First MI):	DOB:	Age:	PEHP ID #:			
(Please check service being requested.)		QUESTION (cont'd)		YES	NO	COMMENTS/NOTES
B. <input type="checkbox"/> <u>Speech Therapy:</u>						
1. Is speech delay associated with a specifically diagnosable disease, injury, or congenital defect (e.g. cleft palate, cleft lip, congenital deafness, etc.)?				<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the speech-language disorder the result of a non-chronic disease or acute injury?				<input type="checkbox"/>	<input type="checkbox"/>	
3. Is therapy treatment for a congenital oral/pharyngeal anomaly, such as cleft lip, cleft palate, ankyloglossia (tongue-tie), and macroglossia (large tongue)?				<input type="checkbox"/>	<input type="checkbox"/>	
4. Is the patient receiving treatment for any of the following injuries that have affected speech? <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> History of chronic otitis media in infancy that caused damage resulting in hearing loss <input type="checkbox"/> Static Encephalopathy <input type="checkbox"/> Stroke/CVA (Cerebrovascular Accident) <input type="checkbox"/> Trauma <input type="checkbox"/> Vocal cord injury (e. g., edema, nodules)				<input type="checkbox"/>	<input type="checkbox"/>	
5. Is speech therapy being requested for mixed receptive-expressive language disorder?				<input type="checkbox"/>	<input type="checkbox"/>	
6. Did the patient have implantation of a cochlear implant? Date: _____				<input type="checkbox"/>	<input type="checkbox"/>	
7. Is the patient receiving both occupational <u>and</u> speech therapy, but the therapies are providing different treatments and do not duplicate the same treatment?				<input type="checkbox"/>	<input type="checkbox"/>	
8. Has the patient achieved therapeutic goals of the treatment plan and no further functional progress is expected to occur, but therapy is to continue as part of a maintenance program?				<input type="checkbox"/>	<input type="checkbox"/>	
9. Can therapy, such as treatment to maintain function by using routine, repetitious, & reinforced procedures be carried out effectively by the patient, family, or caregivers at home on their own instead of a qualified provider of speech therapy services?				<input type="checkbox"/>	<input type="checkbox"/>	
10. Does the patient have a speech dysfunction that is self-correcting (i.e. natural dysfluency, developmental articulation error)?				<input type="checkbox"/>	<input type="checkbox"/>	
11. Is speech therapy primarily educational in nature (such as treatment of pervasive developmental disorders or mental retardation)?				<input type="checkbox"/>	<input type="checkbox"/>	
12. Does the patient have idiopathic delays in speech development and is less than 18 months old?				<input type="checkbox"/>	<input type="checkbox"/>	
13. Does the patient have any of the following conditions? <i>Please check all that apply.</i> <input type="checkbox"/> Attention Disorder <input type="checkbox"/> Behavioral problem <input type="checkbox"/> Conceptual handicap <input type="checkbox"/> Idiopathic speech delay <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Psychosocial speech delay <input type="checkbox"/> Stuttering/Stammering <u>not</u> related to a specific disease or brain injury <input type="checkbox"/> Verbal Apraxia				<input type="checkbox"/>	<input type="checkbox"/>	
C. <input type="checkbox"/> <u>Voice Therapy:</u>						
1. Does the patient need to restore the ability to produce speech sounds due to any of the following conditions? <i>Please check all that apply.</i> <input type="checkbox"/> Essential voice tremor <input type="checkbox"/> Paradoxical vocal cord motion disorder (PVCM) <input type="checkbox"/> Muscle tension dysphonia (functional dysphonia) <input type="checkbox"/> Spastic (spasmodic) dysphonia <input type="checkbox"/> Status post-surgery on the vocal cords <input type="checkbox"/> Status post treatment for laryngeal (glottic) carcinoma <input type="checkbox"/> Traumatic injury to vocal cords <input type="checkbox"/> Vocal cord nodules <input type="checkbox"/> Vocal cord paralysis				<input type="checkbox"/>	<input type="checkbox"/>	
2. Is voice therapy being ordered for any of the following conditions? <i>Please check all that apply.</i> <input type="checkbox"/> Improvement of voice quality <input type="checkbox"/> Neuromuscular disorder, such as Parkinson's Disease <input type="checkbox"/> Occupational or recreational purposes (e.g. public speaking, singing, etc.) <input type="checkbox"/> Self-limited condition, such as acute laryngitis				<input type="checkbox"/>	<input type="checkbox"/>	
Additional Comments: <div style="height: 40px; border: 1px solid black; margin-top: 5px;"></div>						

***Please fax completed form and medical records to 801-366-7449.**