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MASSACHUSETTS

SHORT-TERM REHABILITATION SPEECH THERAPY EXTENSION REQUEST FORM

Please attach initial evaluation and most recent progress summary and fax to Health & Medical Management at **1-888-282-0780**, or:
For Blue Cross employees, please fax to: **1-617-246-4299**
For Medicare Advantage members, please fax to: **1-800-447-2994**

MEMBER INFORMATION

Member name:	
Date of birth:	
Subscriber name:	
Subscriber ID:	
Referral/authorization #:	
Treatment diagnosis:	
Medical diagnosis:	
Date of onset/exacerbation:	
Initial evaluation date for current diagnosis:	
Previous treatment for this diagnosis:	
Treatment for other diagnoses (within the previous year):	

PROVIDER INFORMATION

Provider name:	
NPI:	
Therapist name:	
Phone #:	
Fax #:	
Contact name:	
Referring MD:	
MD Phone #:	

REQUESTED SERVICES

Extension start date:		Anticipated discharge date:	
# of visits requested:			
Is the member receiving speech therapy elsewhere? *(check all applicable)*	❑ School ❑ Early Intervention ❑ Other:		

TREATMENT INFORMATION: PLEASE NOTE, OBJECTIVE CLINICAL MEASURES MUST BE PROVIDED TO DEMONSTRATE PROGRESS

Goals:	Initial evaluation goal status (1st extension request only):	Previous goal status:	Current goal status:	New short-term or long-term goals (if any):
1.				
2.				
3.				
4.				

Has the member demonstrated an improvement in communicating their functional and ADL needs? ❑ Yes ❑ No

Is any portion of this treatment completed as therapy on horseback (hippotherapy)? ❑ Yes ❑ No