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MASSACHUSETTS

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Short-Term Rehabilitation Speech Therapy Extension Request Form

Please attach initial evaluation and most recent progress summary and fax to:
BCBSMA Clinical Coordination Department at 1-888-282-0780
For BCBSMA employees, please fax to: 617-246-4299
For Medicare Advantage members, please fax to: 1-800-447-2994

Patient Information:		**Provider Information:**	
Member name:		Provider name:	
Date of birth:	/ /	NPI:	
Subscriber name:		Therapist name:	
Subscriber ID:		Telephone:	( )
Referral/Authorization #:		Fax:	( )
Treatment diagnosis:			
Medical diagnosis:		Contact name:	
Date of onset/exacerbation:	/ /	Referring MD:	
Evaluation date for current diagnosis:	/ /	MD telephone #:	( )

Previous treatment for this diagnosis:

Treatment for other diagnoses (within the previous year):

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 his/her functional and ADL needs? ❑ Yes ❑ No

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