Millenium Home Health Care
SPEECH THERAPY AUTHORIZATION REQUEST

Date of Request: _____ Initial ST Evaluation Date: _____

Client Name: _____ Insurance Company: _____

Ordering Physician: _____ Physician Phone #: _____

Diagnosis: _____

Caregiver Status: ☐ Spouse ☐ Child ☐ Parent ☐ Other ☐ None

ST *(specific findings, assessment, strengths/weaknesses, problems)* _____

_____

_____

_____

_____

_____

Plan of Treatment:

☐ Assessment and Evaluation ☐ Cognitive Deficit ☐ Sentence Recognition ☐ Word Finding

☐ New/Change in Therapy Plan ☐ Speech Retraining ☐ Verbal Motor Training

☐ Home Exercise Program ☐ Safety Precautions ☐ Aspiration Precaution/Feeding

☐ Other _____

Goals: _____

_____

Progress at this time: ☐ None ☐ Plateau ☐ Minimal ☐ Moderate ☐ Significant ☐ Goal Met

Request for further ST visits as follows: _____

_____

_____

_____

☐ Initial Authorization # Visits Requested _____ Start Date: _____ End Date: _____

☐ Extension of Time Only Requested End Date: _____

☐ Reauthorization # Visits Requested _____ Start Date: _____ End Date: _____