PROVIDENCE SPEECH AND HEARING CENTER

Initial Evaluation Referral Request Form for Occupational, Physical & Speech Therapy

Scheduling Line: 714.639.4990 **Fax: 714.744-3841**

Thank you for referring your patient to Providence Speech and Hearing Center. To better serve you and your patient, please provide us with the following information by fax.

☐ **This COMPLETED Form**

☐ **Patient Demographics Copy of Insurance Card**

☐ **Legible Medical Records/Clinical Notes supporting the reason for the referral and diagnosis**

Insurance Authorization made out to: CHOCProvidenceSpeechandHearingCenter (Please include CPT or HCPC codes for the requested referral)

PatientInformation

Patient Name: _____ Date of Birth: _____

ICD 10/Chief Complaint: _____

Parent/Guardian Language: _____ Patient Language: _____

Please indicate the services you are requesting and ensure all codes are included on the authorization:

☐ **Occupational Therapy Evaluation** (Commercial/BS Promise: 97165, 97166, 97167 or Medi-Cal: X4100-1, X4102-8)

☐ **Physical Therapy Evaluation** (Commercial/BS Promise: 97161, 97162, 97163 or Medi-Cal: X3920-1, X3922-8)

☐ **Speech Evaluation 0-3 yrs old** (Commercial/BS Promise: 92523 or Medi-Cal: X4300-1, X4301-1)

☐ **Speech Evaluation 4 yrs and** older (Commercial/BS Promise: 92521, 92522, 92523, 92524 or Medi-Cal: X4300-1, X4301-1)

☐ **AAC Evaluation** (Commercial/BS Promise: 92607-1, 92608-2 or X4310-1, X4312-1)

☐ **Cranio Speech Evaluation** (Commercial/BS Promise: 92523, 92524 or Medi-Cal: X4300-1, X4301-1)

☐ **OT/ST Feeding/Swallowing Evaluation** (Commercial/BS Promise: 92610 or Medi-Cal: X4301-1 and X4100-1, X4102-2)

☐ **Voice Evaluation (** Commercial/BS Promise: 92520, 92524)

☐ **Other:**_____

Physician Stamp

(Provider Name, Address, Phone No., Lic., NPI)

Provider Signature: _____ **Date:** _____ **Time:** _____

Updated 01.05.24