



SPEECH THERAPY PRE-TREATMENT REQUEST

Please return below form and clinicals to Attn: Utilization Management

Fax: (855) 999-3896

**Mail: Allegiance Benefit Plan Management, Inc.
P.O. Box 3018**

Phone: (800) 877-1122

Missoula, MT 59806-3018

INFORMATION MUST BE SUBMITTED BY ORDERING PHYSICIAN

Sent By: _____

Patient Name:	Patient Health Plan ID:	Patient Plan Group #:	Patient Date of Birth:
Provider Name:	Provider Address:	Provider TIN & NPI:	Provider Phone: Provider Fax:
Facility Name:	Facility Address:	Facility TIN & NPI:	Facility Phone: Facility Fax:
Requested Date:		Scheduled Date:	
CPT Codes:		ICD-10 Codes:	

Inpatient

Outpatient

Please provide the following information:

1. A complete description of the procedure(s) or treatment(s) for which pre-treatment is requested;
2. A completed diagnosis and all medical records regarding the condition that supports the request procedure(s) or treatment(s);
3. An itemized statement of the cost of such procedure(s) or treatment(s) with corresponding CPT or HCPCS codes;
4. A physician's referral letter, if applicable;
5. A letter of medical necessity;
6. A written treatment plan, including frequency and duration of expected treatment; and
7. An evaluation by an appropriate health provider.

Upon receipt of all required information, the Plan will provide a written response to the written request for pre-treatment. Please allow 3 business days for a response.

The benefits available are conditional on the participant's employment status, plan eligibility, payment of premium, amount of benefits remaining, plan provisions and plan exclusions. If information obtained at the time of claim places the service(s) in an excluded category or definition, the claim will not be payable. The benefits quoted are not guaranteed. Final determination of benefits to be paid will be made at the time a claim is submitted for payment, with review of the necessary medical records and other information.