SPEECH THERAPY PRE-TREATMENT REQUEST

Please Return this cover sheet and all required information to: Attn: Medical Review

Fax: (406) 532-3513

Phone: (800) 877-1122

Mail: **Allegiance Benefit Plan Management, Inc.**
P.O. Box 3018
Missoula, MT 59806-3018

INFORMATION MUST BE SUBMITTED BY ORDERING PHYSICIAN

Sent By: _____

Patient Name:	Patient Health Plan ID #:	Patient Date of Birth:
Provider Name:	Provider TIN:	Provider Phone: Provider Fax:

Request Date:	Scheduled Date:
CPT:	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 preauthorization. Please allow 3-5 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.