Horizon

Horizon NJ Health

Date of Request: _____

In place of this form you can submit Authorization Requests online securely via NaviNet. If you are not registered, please visit NaviNet.net and click *Sign Up* or call NaviNet Customer Care at 1-888-482-8057.

Speech Therapy Authorization Request Form Fax

completed form to: Horizon NJ Health **1-609-583-3042**

General Information

Member Name: _____ **Member ID #:** _____ **DOB:** _____

List Any Additional Insurance: _____

For New and Continued Service Requests - Medical Information Required

Speech Therapy: Visits per Week: _____ **Total Visits Requested:** _____ **Dates of Service (From/To):** _____

CPT Codes Requested: _____

Primary Diagnosis: _____ **Other Chronic Diagnoses:** _____

ICD-10 Code: _____

ICD-10 Code: _____

Required Information (please attach brief treatment plan and any supporting documentation)

Characteristics of Speech Issue: **Severity:** □ **Mild** □ **Moderate** □ **Severe**

Duration or Age of Onset: _____ **Secondary Behaviors:** _____

Clinical or Functional Impact: _____

Other/Additional History: _____

Treatment Plan Including Frequency& Duration: _____

Short -Term Goal: _____

Long -Term Goal: _____

Member Name: _____ **Member ID #:** _____ **DOB:** _____

Is member receiving any other therapies? _____ **Yes** _____ **No**

If member is younger than 18, does member have Individual Educational Plan or Early Intervention Plan? _____ **Yes** _____ **No**

Is member receiving services from any other source, such as school-based therapy? _____ **Yes** _____ **No**

Additional Required Information

Servicing Provider/Facility: _____ **ID # & NPI #:** _____ **TIN #:** _____

Facility Address: _____

Provider Contact Name: _____ **Phone #:** _____ **Fax #:** _____