SPEECH SOLUTIONS

Speech Therapy and Orofacial Myology

Our help means more than words

Getting Authorization for Speech Therapy doesn't have to be difficult!

Please complete the following steps:

1.) Make an appointment with you or your child's Primary Care Doctor (PCM).

2.) Hand this authorization paperwork to him or her.

3.) Ask your Primary Care Physician to fill in their information.

4.) Have your Primary Care Physician fax this form to Tricare.

Please give us a call if you have any questions. (808) 596-0099.

UnitedHealthcare MILITARY & VETERANS

TRICARE Service Request/Notification

Service requests may be entered directly by registered providers at uhcmilitarywest.com

Fax referral to: UnitedHealthcare Military & Veterans at:

(Check one)
- ☑ **877-890-9309 Routine**
- ☐ **877-890-8203 Urgent** ***(Care needed within 72 hours)***
- ☐ **877-578-2738 Inpatient**

Anticipated Date of Service: __/__/____

Admission Type:
- ☐ ER
- ☐ Direct Admit
- ☐ Elective

Service Type: (Check one)
- ☐ Specialty Referral
- ☑ Outpatient (Medical/Surgical/Home Health)
- ☐ Inpatient (Acute, SNF, or Rehab)
- ☐ DME

Beneficiary Information (Completion of **ALL** fields is **REQUIRED**)

Last Name:	First Name:	M.I.:	Gender:	DOB: (mm/dd/yyyy)

Address: Street	Apt. No.:	City:	State:	ZIP Code:

Contact Phone #:

- ☐ Sponsor SSN
- ☐ Benefits Number (found on *back* of ID card):

Diagnostic Information (REQUIRED FOR ALL REQUESTS: Diagnosis codes and Episode of Care Name and/or CPT Codes)

Diagnoses (ICD Code(s)): F80.2, R63.3

Diagnosis Description: Receptive/Expressive Language Dx / Muscle Coordination Dx

Episode of Care: Therapy ST

(ATTN: Use exact name from EOC Reference Table available at www.uhcmilitarywest.com)

CPT 4 Code(s) / HCPCS Code(s):	# of Units:	CPT 4 Code(s) / HCPCS Code(s):	# of Units:
92526	52	97535	52
92507	52		
92508	52		

Clinical Information/Description of Requested Service (Include attachments as needed)**:**

Requesting Provider Information (Do not use group name) (Completion of **ALL** fields is **REQUIRED**)

Last Name:	First Name:	NPI #:

Address: Street	Suite:	City:	State:	ZIP Code:

Office Phone #:	Office Fax #:

Contact Name:	Contact Department:

Servicing Provider (Check One) ☐ Physician ☑ Facility ☐ Agency ☐ Vendor

Last Name or Entity Name **(Required)**:	First Name **(Required for Physician):**	☑ NPI 1356673727 ☐ TIN
Speech Solutions		

Address **(Required)**: Street	Suite:	City:	State:	ZIP Code:
725 Kapiolani Blvd.	C206	Honolulu	HI	96813

Specialty (**Required)**:	Office Phone #:	Office Fax #:
Speech Pathology	(808) 596-0099	1-888-331-0723

Servicing Facility (Required if applicable)

(Check One) ☐ Acute Inpatient ☑ Outpatient ☐ Skilled Nursing ☐ Observation ☐ Rehabilitation

Facility Name: Speech Pathology of Hawaii DBA Speech Solutions

☐ NPI ☑ TIN W8672793-01

Address: Street	Suite:	City:	State:	ZIP Code:
725 Kapiolani Blvd	C206	Honolulu	HI	96813

Office Phone:	Office Fax:
(808) 596-0099	1-888-331-0723