

***Referral form for families needing a communication device
for Augmentative and Alternative Communication (AAC)***

Parent instructions: *Bring this form to your pediatrician/family physician when requesting a prescription to start the AAC evaluation process. Once your physician provides the prescription, call the insurance company to choose an AAC evaluation agency. The numbers are listed below:*

Mercy Care AAC at 602-263-3000

(Ask for member services)

United Healthcare AAC at 602-255-1608

Client name: _____ **Date of Birth:** _____

Speech-Language Pathologist's Statement of Medical Necessity: *(How are communication deficits impacting the client's ability to communicate? Can the client use speech for a variety of purposes in a variety of settings, with a variety of partners? How does their communication disorder limit them?) Explain.*

Dates the client was treated for speech/language disorder: _____ to _____

Signed by Treating Speech Language Pathologist: _____ **Date:** _____

(CF requires supervisor signature with CCC)

Treating SLP's Contact Info: (Printed name) _____ **(phone/email)** _____

ASHA Statement of Communication Bill of Rights: This client is in need of an AAC device. The right to communicate is recognized as a fundamental human right in accordance with the *American Speech-Language Hearing Association's* position in conjunction with the *National Joint Committee for the Communication Needs of Persons with Severe Communication Needs*. For more information, please go to: <https://www.asha.org/njc/>

Physician Instructions: *Please ensure your prescription includes the following information:*

Wording: Request an "AAC evaluation" and use ICD-10 Code **92607**

Provide client's primary medical diagnosis and ICD-10 Code(s)

Physician Signature:

Physician's NPI #: