ArSHA
Arizona Speech-Language-Hearing Association

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

Instrucciones para los padres: lleve este formulario a su pediatra / médico de familia cuando solicite una receta para comenzar el proceso de evaluación de AAC. Una vez que su médico le proporcione la receta, llame a la compañía de seguros para elegir una agencia de evaluación de AAC. Los números se enumeran a continuación: Mercy Care AAC al 602-263-3000 United Healthcare AAC al 602-255-1608.

Nombre del cliente: _____ (name) Fecha de nacimiento: _____(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 CPT Code **92607**

Provide client's primary medical diagnosis and CPT Code(s)

Physician Signature:

Physician's NPI #: