advantage
speech therapy services



Verification of benefits information

Kid's name & DOB	NAME: _____ DOB: _____
Diagnosis being verified	☐ ASD f84.0 ☐ Receptive/Expressive Language F80.2 ☐ Expressive language only f80.1 ☐ Phonological (speech errors) f80.0 ☐ Fluency f80.81
Name of Insurance & ID Address for Claims:	NAME OF COMPANY. _____ PHONE # _____ ID # _____ ADDRESS: _____
Date range of authorization *if not a calendar year	
Is an auth needed for therapy and/or eval (procedure codes)	Fee schedule 92507: _____ Fee schedule 92521: _____ Fee schedule 92523: _____ Fee schedule 92522: _____
# of visits per calendar year *indicate if any have been used	☐ SPECIFIC # _____ ☐ UNLIMITED
What locations are permitted [home, office (aka school), and teletherapy]	☐ HOME ☐ OFFICE (this is what we use for daycares/ABA centers) ☐ TELETHERAPY
Status of deductible (does it apply? How much has been used?)	
Amount of anticipated copay.	
AGENT SPOKEN TO & REFERENCE #	ASTS NPI # 1225444821. REFERENCE # _____ Date of Call: _____