



STATE OF NORTH CAROLINA
TEACHERS' AND STATE EMPLOYEES'
COMPREHENSIVE MAJOR MEDICAL PLAN
AND NC HEALTH CHOICE

MEDICAL RECORD REQUEST

DATE:	PROVIDER FAX NUMBER:
PATIENT NAME:	ID NUMBER:
PROVIDER NAME:	PROVIDER PHONE NUMBER:
REF #	DOS:

We received your request for coverage for Speech Therapy. In order to evaluate your request we need the following records:

- Initial evaluation (Include formal testing; mention of the cause such as sensorineural hearing loss, cleft palate, etc); specific and measurable short and long-term goals with reasonable and predictable time frames
- Physiological/Audiometric/Pure Tone Hearing Screening
- Copies of any serial formal testing (to evaluate progress towards the long term goals)
- Specific and measurable long term goals with reasonable and predictable time frames for completion. These are the expected goals as an outcome of providing therapy, not interim goals. If you are unable to predict where therapy is leading and how long it will take, include that information
- Clear evidence whether the specific and measurable short term goals were met or not met. Please include quantitative baseline performance on short-term goals **and** quantitative performance based on recent re-assessment of the same goals
- If the child has been evaluated for special services or the child is receiving or eligible for services through the school, individual education plan (IEP) or if the child is less than 3 yrs of age, individual family services plan (IFSP)

Failure to supply this information by _____ will result in non-certification due to lack of documentation.

Please return one copy of this form with the requested documentation for correct routing. As with all other medical information, these records will be kept strictly confidential for use only by the Plan in determining benefits.

Sincerely,

Medical Review Analyst
 Medical Review Section
 Claims Processing Contractor

PHONE NUMBER: 800-422-1582
 FAX NUMBER: 919-765-4890

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