Initial Evaluation Request for Therapy: Supplemental Information

This form must be included with the prior authorization form, any pertinent clinical documentation and submitted to Superior's Secure Provider Portal at Provider.SuperiorHealthPlan.com or faxed to 1-800-690-7030.

MEMBER INFORMATION

Member Name: ______________________ DOB: _____________ Medicaid ID: _________________________

Medical Diagnoses: ____

Discipline(s) being requested: ____

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TEXAS HEALTH STEPS EXAM INFORMATION
(For members under 18 years old)

Date of most recent Texas Health Steps exam: ____
Please note: must be current per the Texas Health Steps Periodicity Schedule.

Summary of findings (to include any concerns): ____

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SCREENING INFORMATION
(If applicable)

Developmental Screening (required for members under six years old with developmental concerns):

Date of most recent screening: ____
Please note: must be current per the Texas Health Steps Periodicity Schedule.

If formal screening conducted, name of the screening tool: ____

Concerns identified: (check all that apply)

- ☐ Expressive language
- ☐ Feeding/swallowing
- ☐ Fine motor
- ☐ Gross motor
- ☐ Receptive language Sensory
- ☐ Self help
- ☐ Sensory
- ☐ Social/emotional
- ☐ Speech intelligibility

Other: ____

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Summary of any additional developmental surveillance (to include any positive or concerning results):

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If the member is over six years old, please specify the medical necessity reason for therapy referral:

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Hearing Screening (required for members under six years old requesting speech therapy):

Date of the most recent hearing screening: ______________________________________

Please note: must be current per the Texas Health Steps Periodicity Schedule.

Findings: (circle one) Pass / Fail

If failed or unable to perform, please provide additional information to include plan for audiological assessment referral or results if an assessments was already performed:

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ACKNOWLEDGEMENT

I certify that the information entered above is true and correct to the best of my knowledge.

____ ___________________________

Physician Signature Date