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: _____

_____

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): _____

_____

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):

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

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

In the case of behavioral issues or inability to participate in the hearing screen, an objective description of the behavioral issues and/or inability to participate in the hearing screen along with a statement as to why hearing deficit is not suspected. Please specify below and/or attach documentation, if applicable.

In the case of suspected hearing deficit, documentation of a referral to an audiologist or physician who offers auditory services must be included in in the clinical documentation submitted. If applicable, please attach documentation when this request is submitted.

ACKNOWLEDGEMENT

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

Physician Signature _____ Date _____