SpeechVive— Reimbursement Checklist

Use the following checklist to gather the information required to pursue insurance reimbursement for the SpeechVive communication device.

Complete the Following Documents included in the Packet:

Physician to Complete:

- Physician's prescription (specifically lists SpeechVive)
- Physician chart notes documenting communication disorder and need for SpeechVive

Documents to obtain and include in Packet:

- Insurance cards (clear copies, front and back)
- Speech-language pathologist evaluation, if completed.

Please send the completed reimbursement packet to:

Abililife
Attn: SpeechVive Insurance Eligibility
via email orders@abililife.com or fax 844-335-8496

You may reach AbiliLife at

100 South Commons
Ste 102
Pittsburgh, PA 15212
Phone: 855-379-6283 Fax:
**Please retain a copy of the reimbursement packet for your records

Physician Prescription

To be completed by physician **Order Request Date: ___________**

Patient Information

Patient Last Name:___________________Patient First Name:_________________DOB: __________

Patient Full Address:________________________Primary Phone: ____________________

__________________________ Alt. Phone: _____________________

__________________________ Email: ________________________

Please include back and front of insurance cards and patient's chart notes.

Clinician Information

HCPC Code:

____E1399

Medical Diagnosis (select all that apply):
___G20 Parkinson's disease ___Other (Please include ICD-10 code) _____________________

Communication Diagnosis (select all that apply)
___R47.1 Dysarthria ___R47.81 Slurred Speech____R49.0 Dysphonia

___R49.8 Other voice and resonance disorders

___Other (please include ICD-10 code) ____

Prognosis: Good with use of SpeechVive durable medical equipment _____

Other: ____

Date of last face-to-face visit (must be within last 6 months): ______________________________
Equipment Prescribed: SpeechVive device________(Right Ear) (Left Ear)
Physician Information:
The device prescribed is medically necessary for this patient to achieve functional communication efficiently and effectively across settings for communication with caregivers and medical providers in person and via the telephone to access emergency services.

Physician Printed Name:_______________________________________NPI: _________________

Medicaid ID:_____________________________________Phone: __________________________

Address :____

Physician Signature:____***Date:*** _________________

Please include patient's chart notes.

 Please email this form to Orders@abililife.com or fax to 844-335-8496

Speech-Language Pathologist (SLP)

If the patient has seen a speech-language pathologist and had a speech/communication evaluation completed, please complete this section.

SLP Full Name: ______________________________

Facility Name: ______________________________

Facility Address: ______________________________
____
____

Office Phone #: ______________ Office Fax #: ______________

Please include patient's chart notes and evaluation.

 Please email this form to Orders@abililife.com or fax to 844-335-8496