# 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)

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

## Attn: Preauthorization Department

Patient's Name: ____________________________________________________________
Patient's date of birth _________________________________________________________
Patient's health plan name and ID# _______________________________________________

Dear Sir/Madam:
This letter is to request prior authorization for a SpeechVive device, durable medical equipment, to treat dysarthria and hypophonia which has significantly impacted the patient's voice volume and ability to communicate clearly and effectively. The patient has been diagnosed as follows:

<u>Medical Diagnosis (select all that apply):</u>

_____G20 Parkinson's disease _____Other (please include ICD-10 code) _____________

<u>Communication Diagnosis (select all that apply)</u>

_____ R47.1 Dysarthria _____ R47.81 Slurred speech_____ R49.0 Dysphonia

_____ R49.8 Other voice and resonance disorders

_____ Other (please include ICD-10 code) ______________________________________

<u>Equipment prescribed:</u>

_____ SpeechVive device _____ (Right Ear) or (Left Ear)

The SpeechVive device meets the definition of a prosthetic device as defined in the Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services, Section 120 which states "…or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ are covered with furnished on a physician's order and as such should be a covered and reimbursable service. The device and be listed under HCPC code E1399.

In summary, based on my clinical observations and medical opinion, I believe ______________ would benefit from the use of SpeechVive. This innovative technology is medically necessary, and I request confirmation that you will approve this prosthetic device as medically necessary and eligible for coverage.

Thank you for your consideration. If you have questions, please feel free to contact me.

Physician printed name: _________________________________ NPI: ________________

Medicaid ID: ______________________________ Phone: _________________________

Address: __________________________________________________________________

Physician's signature: _______________________________ Date: __________________

## Please include patient's chart notes.

**Speech Language Pathologist (SLP)**

If the patient has been seen by 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.

Send completed physician packet to:

U.S. ☐ MAIL AbiliLife
Attn: SpeechVive Insurance Eligibility
100 South Commons
Ste 102 Phone: 855-379-6283
Pittsburgh, PA 15212

☐ EMAIL orders@abililife.com

FAX ☐ 844-335-8496

# Attn: Preauthorization Department

Patient's Name: ____________________________________________________________
Patient's date of birth _________________________________________________________
Patient's health plan name and ID# _______________________________________________

Dear Sir/Madam:
This letter is to request prior authorization for a SpeechVive device, durable medical equipment, to treat dysarthria and hypophonia which has significantly impacted the patient's voice volume and ability to communicate clearly and effectively. The patient has been diagnosed as follows:

**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) ______________________________________

**Equipment prescribed:**

_____ SpeechVive device _____ (Right Ear) or (Left Ear)

The SpeechVive device meets the definition of a prosthetic device as defined in the Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services, Section 120 which states "…or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ are covered with furnished on a physician's order and as such should be a covered and reimbursable service. The device and be listed under HCPC code E1399.

In summary, based on my clinical observations and medical opinion, I believe ______________ would benefit from the use of SpeechVive. This innovative technology is medically necessary, and I request confirmation that you will approve this prosthetic device as medically necessary and eligible for coverage.

Thank you for your consideration. If you have questions, please feel free to contact me.

Physician printed name: __________________________________ NPI: _________________

Medicaid ID: _______________________________ Phone: __________________________

Address: ____________________________________________________________________

Physician's signature: ________________________________ Date: ___________________

## Please include patient's chart notes.

**Speech Language Pathologist (SLP)**

If the patient has been seen by 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.

Send completed physician packet to:

U.S. ☐ MAIL AbiliLife
Attn: SpeechVive Insurance Eligibility
100 South Commons
Ste 102 Phone: 855-379-6283
Pittsburgh, PA 15212

☐ EMAIL orders@abililife.com

FAX ☐ 844-335-8496