SpeechVive

603 Wexford Drive, Lafayette, IN 47905 | **speechvive.com**

RETURN BY FAX TO (888) 375-0987 or email orders@speechviveorders.com

Patient's Name: _____ Patient's DOB: _____

Patient's Best Phone Number: _____Patient's Email for Order Confirmation: _____

Primary Insurance: ☐ **Traditional Medicare #: _____**

☐ **Medicare Advantage #: _____**

Secondary Insurance: Health Plan Name & Number: _____

Equipment prescribed:

Speechvive Device **HCPCS Code K1009** – Speech volume modulation system, any type, including all components and accessories.

The SpeechVive device is a piece of durable medical equipment (DME) that addresses the symptoms associated with dysarthria for patients having trouble with speech volume and clarity due to Parkinson's disease.

Length of need – ☐ 99 (Lifetime unless advised) ☐ Other_____ Quantity prescribed – 1

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 & resonance disorders	☐ Other (Include ICD-10 code) _____

Please circle if known or SpeechVive will contact patient: Right Ear or Left Ear

REQUIRED

Other available interventions for hypophonia such as LSVT Loud, Speak Out, speech therapy, or a personal amplifier are not appropriate at this time due to: **(Check all appropriate)**

☐ Significant patient and caregiver burden required to attend intensive speech therapy sessions

☐ Speech therapy has been ineffective in the past

☐ Other: _____

☐ Medicare requires chart notes documenting communication disorder and need for the SpeechVive device.

☐ I can attest that this patient presents with the communication diagnosis(es) outlined above and the SpeechVive device is medically necessary and prescribed to compensate for the patient's communication disorder and provide them with an effective and efficient means to verbal communication.

Prescribing Physician Information:

Physician's printed name: _____ NPI: _____

Phone: _____ Fax: _____Address: _____

Physician's signature: _____ Date: _____

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Medequip

Medicare claims processed by Medequip

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Please Sign the Assignment of Benefits

Medicare and Insurance companies require permission in order for them to pay for your healthcare, whether a SpeechVive device or a doctor's visit.

Before SpeechVive can ship your device to you, we need you to authorize SpeechVive's Medicare DME partner, Medequip, to submit your order to Medicare and any other health insurance company for reimbursement.

By agreeing to this Assignment of Benefits, you authorize the DME Supplier, Medequip, to submit claims to Medicare and your health insurance company on your behalf for reimbursement and coverage of your SpeechVive. You also authorize to request on your behalf any prescriptions, medical records, and/or insurance information to any person or organization which may be involved in providing your care.

SpeechVive will confirm with you the details of your order prior to shipment.

_____
Patient or Power of Attorney Signature*(required)

_____
Print First and Last Name*(required)

_____
Date*(required)

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