Mass General Brigham
Newton-Wellesley Hospital

Newton-Wellesley Hospital Rehabilitation Services

Thank you for contacting us about your child's speech and language evaluation. As we may have discussed on the telephone, we will need the following information completed and returned to us as soon as possible before we can schedule an evaluation appointment for your child:

- **Completed and signed Pediatric Speech-Language Pathology History Form**
- **Copies of any previous speech, language, hearing and learning evaluations**
- **Copies of IEPs or 504 Educational plans**
- **If your child is not yet registered as a patient at NWH, or if you have any new insurance changes, please call our Patient Service Center prior to scheduling at 855-890-9241**

Once we receive this information from you, we will then contact you to schedule your child's appointment. Please note that new patient evaluations are typically scheduled for approximately 2 hours on Tuesdays, Thursdays, and Fridays.

We look forward to working with your family to address your concerns about your child's communication abilities. If you have further questions, please contact the Pediatric Speech Department at **617-243-6172**.

Please send a completed copy to **NWHRehabPediSpeech@partners.org**, fax it to **617-243-6651** or mail the form to the following address:

Newton-Wellesley Ambulatory Care Center
Attn: Pediatric Speech and Language Department Speech Therapy Intake Appt.
159 Wells Avenue
Newton, MA 02459

Sincerely,

Newton-Wellesley Hospital Rehabilitation Services

Name: _____

Date of birth: _____

Date: _____

Pediatric speech and language pathology history form

Child's full name: _____ Birth date: _____
Home phone: _____ Work: _____ Cell: _____
Address: _____
Email: _____ Zip Code: _____

Insurance Name: _____ Insurance #: _____
Subscriber's name: _____ Subscriber's birth date: _____
Person completing form: _____ Today's date: _____
Relationship to child: _____
Parent name: _____ Age: _____ Occupation: _____
Parent name: _____ Age: _____ Occupation: _____
Pediatrician: _____ Phone: _____ Fax: _____
With whom does your child live: _____
Siblings (names and ages): _____
Languages spoken in the home: _____
How did you hear about us? _____

Description of the problem:

What do you hope to learn from this evaluation?

_____

Please describe your child's speech-language or learning problems:

_____

When did you first become aware of the problem:

_____

How has the problem changed since you first became aware of it:

_____

Are there situations where the problem seems worse and/or better:

_____

Pregnancy and birth history:

Were there any difficulties during pregnancy? Explain: _____

_____

Length of pregnancy: _____ Birth Weight: _____ Apgar Score: _____

Were there any difficulties during labor? Explain: _____

_____

Were there any feeding, sucking, swallowing, or sleep difficulties during infancy?
Explain: _____

Name: _____

Date of birth: _____

Medical history

Does your child have any medical diagnoses? Please list:

_____

Is your child taking any medications? Which ones and for what?

_____

List any serious illness, surgeries, or accidents with dates:

_____

Did your child have any ear infections as a toddler? If so, how many?

_____

How were the infections treated? (Antibiotics, tube placement, other)

_____

Date and place of your child's most recent hearing test and the results:

_____

Date and place of your child's most recent vision examination and the results:

_____

Are immunizations up-to-date? _____

Developmental history – at what age did the following occur:

Sat alone: _____ Stood Alone: _____ Walked unaided: _____

What hand does the child prefer: _____ Bowel trained: _____ Bladder trained: _____

Babbled (repeated consonant plus vowel production): _____

First word: _____ Example: _____

Estimated current vocabulary size: _____

Combined two words: _____ Example: _____

First sentences: _____ Example: _____

Do you have any concerns about your child's feeding or swallowing? If so, please describe:

_____

Educational and treatment history

Was your child involved in early intervention or any other early special services? Please list type of services provided and frequency: _____

_____

Has your child had previous speech and language, neuropsychological, educational, etc. evaluations and/or treatment? If so, please list below and describe the nature of any intervention. _____

_____

Speech and language evaluations:

Date: _____ Location: _____ Results: _____

Is report attached? _____

Describe treatment (include type, frequency and duration):

_____

Name: _____

Date of birth: _____

Neuropsychological evaluations:

Date: _____ Location: _____ Results: _____

Is report attached? _____

Describe treatment (include type, frequency and duration):

_____

Academic/educational evaluations:

Date: _____ Location: _____ Results: _____

Is report attached? _____

Describe treatment (include type, frequency and duration):

_____

Early intervention evaluations:

Date: _____ Location: _____ Results: _____

Is report attached? _____

Describe treatment (include type, frequency and duration):

_____

Daycare/playgroups/preschool attended by your child:

_____

Educational information:

Current school: _____ Grade: _____ Number of children in class: _____

Do you have any concerns about your child's academic performance? If so, please describe:

_____

Has your child ever received special services in school? Please describe type, frequency and duration:

_____

Social history:

Please describe your child's play habits/skills/interests:

_____

Does your child get along with peers? Explain:

_____

Do any immediate or extended family members have a history of speech, language, learning or mental health problems? If so what is their relationship to the child (Uncle, sister, etc.)? What were their difficulties?

_____

Additional information:

_____

_____

Signature of parent, guardian or other legal representative Date:

_____

Printed name

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Insurance Coverage for Speech and Language Therapy Services

Thank you for choosing Newton-Wellesley Outpatient Rehabilitation Services for you or your family's rehabilitation needs. Our mission is to provide you with the same care we would for a beloved family member. The purpose of this notice is to help you, the member, better understand your benefits and coverage for speech and language therapy and to help you determine whether services at Newton- Wellesley Hospital may be covered under your plan.

Please be advised that no insurance company guarantees payment for speech-language therapy services. If the insurance company reviews the claim, it may be deemed a service or condition is not part of your insurance coverage, and you as the member may receive a bill. It is the patient's responsibility to understand his/her health plan requirements and we ask that you read this form to get a better understanding of what to look for in your insurance plan to understand if you may have financial responsibilities:

Please call your insurance company (the phone number is likely listed on the back of your card) to:

- Clarify your child's benefits for speech-language therapy services
- Determine if speech language services at Newton-Wellesley Hospital will be covered by your insurance plan.

  ☐ Yes ☐ No

It is recommended that you write down the following information when you contact your insurance company:

- Date/time of call: _____
- Name of insurance representative: _____
- Direct contact number/extension for representative: _____
- Confirmation code for the call: _____

The following are some questions to help clarify covered speech therapy services:

Will my insurance plan cover outpatient speech language therapy services at Newton Wellesley Hospital?

☐ Yes ☐ No

Is Newton Wellesley considered in-network for my plan (NPI number: 1992737761)?

☐ Yes ☐ No

What specific conditions/diagnoses will insurance cover? Is there a list of covered diagnosis codes?

_____

What specific condition/diagnoses that are excluded? Is there a list of excluded diagnosis codes?

_____

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Insurance Coverage for Speech and Language Therapy Services

The following is a list of common ICD-10 diagnosis codes and CPT codes used by speech language pathologists that may assist you in verifying insurance coverage. Consider giving the insurance representative both the ICD-10 code that matches your child's existing or suspected diagnosis and the CPT treatment or evaluation code that applies.

ICD-10 Diagnosis Codes

F80.0 Phonological Disorder

F80.1 Expressive Language Disorder

F80.2 Mixed Receptive-Expressive Language Disorder

F80.81 Childhood Onset Fluency Disorder (Stuttering)

R47.1 Dysarthria

R48.8 Other Symbolic Dysfunction (use with **F84.0** Autism as secondary diagnosis if applicable)

R48.8 Other Speech Disturbances

R48.2 Apraxia

R49.0 Dysphonia/Hoarseness (use with **J38.2** Nodules of Vocal Cords as secondary diagnosis if applicable)

M26.59 Other dentofacial functional abnormalities (use with

R47.89 Other Speech Disturbance if applicable)

CPT Treatment Codes

☐ **92507** Individual speech-language treatment

☐ **92508** Group speech-language treatment

CPT Evaluation Codes

☐ **92521** Evaluation of speech fluency (stuttering)

☐ **92522** Evaluation of speech sound production

☐ **92523** Evaluation of speech production AND receptive/expressive language

☐ **92523** Evaluation of voice and resonance

Does my plan require preauthorization, precertification, or a referral for speech language evaluation and therapy services?

☐ Yes ☐ No

How many visits does my insurance cover? ____ Is there a time limit to begin or to end?

☐ Yes ☐ No

Do I have a deductible or co-payment?

☐ Yes ☐ No