GRASSROOTS THERAPY SOLUTIONS

Speech & Language Services

Child's name:	
Child's DOB:	
Referred by:	
Parent's name (primary contact):	
Phone number:	
Email:	
Address:	

Insurance Carrier:	
Subscriber Name:	
Subscriber's DOB:	
Subscriber's Address: (if different from above)	
Subscriber's Phone Number: (if different from above)	
Employer:	
Group Number:	
Member ID Number:	

For Office Use Only:

ICD10: _____ CPT codes: _____

Is pre-authorization required? ☐ Yes ☐ No

Is referral required? ☐ Yes ☐ No

Co-Pay Amount: $_____ Coinsurance: _____

Deductible: Individual: $_____ Family: $_____ Out of Pocket Max: $_____

Progress Towards Deductible to Date: $_____

Number of visits allowed: _____

Additional details / documents needed: