Does my Insurance Benefit Plan Cover Speech Therapy?   sprout therapy services

We created this worksheet to help you determine if your health insurance company will cover speech therapy for your child. If your child has secondary insurance, verify your benefits with both companies. If you have any questions and you are in Colorado Springs, please give us a call at 719-999-8417.

Step 1: Get Ready to Call

Print this document *or* if you prefer, you can fill it out on your computer. Either way, be sure to save it for future reference.

Have your child's current insurance card on hand. If you don't have it, the insurance company should be able to look up your policy with other personal information.

Call the number on the back of the insurance card. If you don't have the card, use gethuman.com/phone-number to lookup the number.

Step 2: Make the Call

After dialing the number, your first goal is to reach an actual person. Once you are connected to a representative write down:

Current Date & Time: _____ Name of Representative: _____

Next, tell the representative:

"*I am calling to check on my benefits and coverage.*"

"*My child needs speech therapy. I would like to speak with someone who can answer my questions about my policy and the rules of coverage for speech therapy.*"

Ask to speak to a supervisor if you feel the representative does not have the information you need.

Step 3: Ask These Questions about **Coverage**

? *"Under what **circumstances** does my policy cover speech therapy?"*

_____

? *"Does my policy have an **exclusion clause** about covering therapy, such as 'therapy will only be covered if the deficit is due to accident, illness or injury'?"* ☐ Yes ☐ No

    ? *If yes, ask, "What is the clause?"*

_____

? *"How **many** visits are allowed per year, per therapy?"* _____

Note: Sometimes Speech Therapy visits are grouped together with Occupational and Physical Therapy visits. If your child receives these services, clarify if the number of visits allowed is shared between all three therapies, or if there is a set number for each discipline.

# of Speech Visits:_____ # of Occupational Therapy Visits:_____ # of Physical Therapy Visits:_____

? *"Have any **visits been used** to date?"* ☐ Yes ☐ No

    ? *"If yes, how many visits are **left**?"*

    # of Speech Visits:_____ # of Occupational Therapy Visits:_____ # of Physical Therapy Visits:____

? *"Do I need **any Pre-Authorization** from child's Primary Care Doctor for Speech Therapy services?"* ☐ Yes ☐ No

    ? *If yes, "What do I need from the **doctor**?" (prescription, medical records, initial evaluation, letter of medical necessity):*

_____

    ? *"How **many sessions** are covered by **each** authorization?"*_____

    ? *"What **period of time** will an authorization cover? (# of months, days, etc.)"* _____

    ? *"Once visits are used up, under what circumstances can my child get **more visits** authorized?"*

_____

continue

⌄

Step 4: Ask These Questions About Co-pays, Co-Insurance, & Deductibles

? *"What are the **dates** of my child's benefit plan?"* _____ *to* _____

? *"What is the **deductible**?"* _____

? *"When does the deductible **start over**?"* _____

? *"How **much** of the deductible has been **met**?" $* _____

? *"Do we have **a co-pay** for speech therapy visits?"* ☐Yes ☐No

    ? *If yes, "How **much** is the copay? Is this per **day** or per therapy **visit**?"*

    *amount: $*_____   *per:* ☐ Day   ☐ Visit

? *"Are we responsible to pay **co-insurance** for speech therapy visits?"* ☐Yes ☐No

    ? *If Yes, "How much is my co-insurance?"* %_____

? *"Do we need to **meet the deductible before** we begin to pay co-pays/co-insurance for Speech Therapy?"* ☐Yes ☐No

Step 5: Ask These Questions About Speech Therapy Providers

? *"Can we choose any certified speech therapist?"* ☐Yes ☐No

? *"Can we choose a therapist outside of our network/provider list?"* ☐Yes ☐No

    ? *If yes, "Is our coverage different outside of the network/provider list?"*

    ☐Yes   ☐No

    ? *If yes, "What is the **difference** in our coverage for **an out-of-network** provider vs. **in-network**?"*

	Out-of-network	In-Network
Deductible:	$_____	$_____
Co-pay:	$_____	$_____
Co-insurance:	%_____	%_____
Out of pocket max:	$_____	$_____
Number of visits:	_____	_____