Speech-Language Therapy
REFERRAL FORM

Patient's Name:_____ DOB: _____

Contact Name:_____ Phone: _____

Reason For Referral: _____

Diagnosis Code (ICD-10):

☐ F80.2	Mixed Expressive-Receptive Language Disorder	☐ R47.89	Other Speech Disturbances
☐ F80.89	Other Developmental Disorders of Speech and Language	☐ OTHER	_____

CPT Code:

☑ Evaluation of Speech Sound Production with Evaluation of Language, Stuttering (92523, 92522, 92521)

☑ Clinical Evaluation of Swallowing/Evaluation of Swallowing Function (92610)

Referring Physician: _____

Office Name: _____

Physician's Signature: _____ **Date**: _____

Insurances Accepted

PPO: BlueCross BlueShield, Anthem, Cigna, United Healthcare, TRICARE, health net

Contracted With: Providence, hoag Medical Group, ADOC Medical Group, RCOC

-We also accept payments from out-of-network providers as well as private pay-

10061 Talbert Ave, Suite 104
Fountain Valley, CA 92708

Phone 1: 714-642-5420

Fax: 714-849-5393

www.avidspeech.com

info@avidspeech.com