



Hamaguchi & Associates
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If You Intend to Seek Insurance Reimbursement

Hamaguchi & Associates is a private-pay practice. We accept checks, major credit cards, or cash. We are not affiliated with any insurance companies and we do not negotiate our fees. You should know that insurance companies often list “speech therapy” as a reimbursable service, but frequently will **not** provide coverage for children’s speech therapy services, particularly if the therapy is not due to a “medical” condition. If you plan to seek insurance reimbursement for any services rendered by Hamaguchi & Associates, you should check with your insurer as to their exclusions and requirements. *Utilizing insurance coverage requires additional steps on our part, and additional expense on yours.* We cannot tell you if your insurance company ultimately will reimburse you for services, even if it lists speech therapy as a covered service. If you still intend to seek insurance reimbursement, you will need to do the following:

1. Before your first visit, you must get a referral from your child’s physician for speech-language therapy services, specifying our name, as well as the amount of therapy (e.g. 45 minutes, twice a week) or that an assessment is being requested. Bring it with you to our office or fax it to our office. We also need a copy of your insurance card, front and back. If we receive a request from your insurance company for this information after you submit receipts, we will not be able to process their requests. Delaying our response while you secure the prescription and get us copies of your card may result in a denial, so it is imperative that you do so first, before submitting your bills to your insurance company. We ask that you also provide your physician with copies of initial speech-language therapy assessments and progress reports so that he/she has the needed information to appropriately make the referral.
2. Insurance companies typically require a written initial assessment. They do not allow us to use the information from your child’s IEP. If we do, it will typically trigger a denial on the grounds that we are duplicating school services or that the therapy is educational-not medical or rehabilitative- in nature. They will allow us to use other, private assessments if they are less than 6 months old as the basis for our treatment, but you should check to find out if they will require a separate assessment from us before initiating therapy. Insurance companies generally require that your child has a formal assessment every year. Our formal assessments include an initial treatment plan.
3. Along with an initial assessment, the insurance company will typically require an initial treatment plan, but not always. If they allow us to use previous assessments, we may *still be required* to write an initial treatment plan. Initial treatment plans are billed at our hourly rate, which is presently \$164. We prefer to do these each September/October or when beginning therapy, since the information is supposed to coincide with the beginning of treatment.

4. Insurance companies may require additional progress reports (quarterly, every 6 months, or annually). These reports are also billed at our hourly rate, which is presently \$164. We may be asked to forward all treatment notes relating to your child's care and will need your permission on the patient history form to do so.
5. We will need to assign your child's therapy a diagnostic code (an ICD-9) code and include it on every receipt. If you do not see one on your child's receipt, please let our front office staff know. The insurance company will require it, and if they have to send the receipts back to us to secure one, it will take much longer for you to be reimbursed. *Please don't ask our staff to use an inaccurate code or change dates of service in order to get reimbursed as that is insurance fraud and we could lose our licenses.*
6. Please make sure that your insurance company writes and sends the reimbursement checks directly to you. All checks sent to this office from an insurance company on behalf of a client will be returned to the insurance company with a letter directing them to reissue the check and send it to you. We cannot deposit, credit your account or co-sign checks that are received by our office in error.
7. In general, our front office staff cannot make calls to your insurance company to follow-up denials or a lack of response from them. Your reimbursement is between you and the insurance company. The only occasion where we will get directly involved and call is when the denial is triggered due to the fact that they did not receive the requested documentation from us. Please know, we do provide the requested documentation in a timely manner, within a week. However, some insurance companies will indicate otherwise in order to drag their feet and limit their financial obligation to you. We keep careful records of when we send out requested information, and so if a denial is triggered for that reason or due to any clerical errors on our part, we will personally follow-up and write whatever letters are needed so you can resubmit your request. Other than that scenario, we will decline to get involved.

Therefore, if you do intend to seek insurance reimbursement, before we proceed with any requests from your insurance company, we require that you adhere to our policies and provide our front office staff with the necessary documents (e.g. copy of your insurance card and physician's prescription) regarding insurance reimbursement.