



FUNDING
Your PRC and Saltlo Funding Source

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION (written order prior to delivery)

1. PATIENT INFORMATION:

Patient First Name: _____ Last Name: _____

Date of Birth: _____ Sex: Male Female Patient's Medical ID #: _____

Email Address: _____ Client Height*: _____ Client Weight*: _____

Address: _____ City: _____

State: _____ Zip: _____ County: _____ Order Date: _____

**Only required for GA Medicaid*

2. CLINICAL INFORMATION:

Diagnosis (medical and/or speech): _____

ICD Code(s): _____

Length of Need: Lifetime Other _____

Date of Appointment between Physician and Patient that Documents need of SGD: _____

If Medicare, progress notes that document the need for an SGD need to be included and date of appointment between physician and patient must be in the last 6 months. Some state medicaid or commercial insurance providers may also have this requirement.

3. DEVICE & RELATED COMPONENTS:

Equipment Being Prescribed: Purchase Rental Repair

Description

4. PHYSICIAN INFORMATION: (To be completed by Physician)

Physician's Name (please print): _____

Address: _____

Phone: _____ Medicaid Provider #: _____ NPI #: _____

I, _____ (print full name of physician), hereby attest that the medical record entry listed above accurately reflects signatures/ notations that I made in my capacity as _____ (insert provider credentials, e.g., M.D.) when I treated/diagnosed the above listed patient in a face to face encounter. I certify that this patient has a medical condition resulting in a severe expressive speech disability such that speaking needs cannot be met using natural communication methods. Patient requires use of a Speech Generating Device as well as the related components listed above. I also certify that their speech will benefit from the device, and that other forms of treatment have been ruled out. My prescription is based on the evaluation I have reviewed and concur with, made by a team, led by the licensed speech-language pathologist, of the patient's physical, language and communication abilities and needs. I attest that the device is medically necessary for the patient's health.

If submitting electronic signatures on medical records, I attest that I used my own ID and password to enter the system to sign the medical records and any prescription. I do hereby attest that this information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. **PHYSICIAN'S SIGNATURE MUST BE LEGIBLE; SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE.**

Physician's Signature: _____ Date: _____