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 medicaids 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: ______________