Certificate of Medical Necessity/Prescription

Name: _____ **DOB:** _____**Today's Date**_____
Address: _____ **Medicaid and/or Insurance Billing #:** _____
_____ _____

Patient Status: To be completed by prescribing physician

Medical Diagnosis or known Medical Problems: _____
_____

ICD Code(s): _____

Significant Medical Information: _____
_____

Medications: _____
_____

Medical Prognosis: _____
_____

I certify that the above named patient requires the use of the Speech Generating Device and related components listed below. My prescription is based on the evaluation of the patient's physical, language and communication abilities and needs made by a team lead by a licensed speech-language pathologist, and the result of a face to face physical examination and evaluation by this physician within the prior twelve month period of this prescription which established the need for the prescribed speech generating device.

_____ _____
Physician's Signature **Physician's Phone**

_____ _____
Print - Physician's Name **Physician's Fax Number**

_____ _____
Physician's Medicaid Provider Number **National Provider Identifier (NPI)**

Device and related components: To be completed by the evaluating Speech-Language Pathologist

Equipment to be: ____Purchased ____Rented _____Repaired _____Updated

Item	Description	Vendor

_____ _____/_____
Print – Speech Language Pathologist Name **SLP Phone** **SLP Fax**

_____ _____
Signature of SLP **Speech-Language Pathologist License Number**

Form Rev 7/11/06