Prescription/Certificate of Medical Necessity (CMN)

Patient Information

Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Equipment Prescribed

The items below must be the specific names of the Device and **ALL** Accessories being prescribed and must match the Speech Evaluation Report (ex:" FRS ComLink LT3G")

Description	HCPC Code

*The above equipment will be: _____ **Purchased** _____ **Rented** _____ **Repaired** _____ **Updated**

*The above equipment will be needed for the ____ months (99 = lifetime)

Patient Status

Diagnosis & ICD-10 Codes: including MR or Speech Related Codes	
Medical Prognosis with use of SGD:	**Good with use of SGD**

Physician/Physician Assistant (PA)/Nurse Practitioner (NP)/Clinical Nurse Specialist (CNS) Information

I certify that the above named patient requires the use of the Speech Generating Device and related components listed above. My prescription is based on the evaluation of the patient's physical, language and communication abilities and needs made by a team led by a licensed speech language pathologist and the result of a face to face encounter by this physician, physician assistant (PA) or nurse practitioner (NP) within the prior 180 days of this prescription which established the need for the prescribed speech generating device. The date of the face to face encounter (must be less than 180 days ago) with patient was _____ (MM/DD/YYYY) to treat their speech related diagnosis mentioned above.

Additionally (Required for Medicare Recipients Only), I certify that I have received a copy of the Speech-Language Pathologist's completed Augmentative Communication Evaluation for the subject patient.

Physician/PA/NP/CNS Signature: _____ **Date**: _____

Physician's Printed First and Last Name:			
National Provider Identifier (NPI)			
Phone:		**Address:**	
Fax:		**City, State, Zip:**	

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