GEORGIA DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATION OF MEDICAL NECESSITY FOR SPEECH GENERATING DEVICES AND MOBILE DEVICES USED AS A SPEECH GENERATING DEVICE WITH AAC THERAPY APPLICATION OR SOFTWARE

SLP ASSESSEMENT REQUIRED

Certification Type/Date: INITIAL _____/_____/_____ REVISED _____/_____/_____	
Members Name: _____	**Members Medicaid Number (Do Not List Mother's ID):** _____
Patient DOB_____/_____/_____ Sex_____ HT._____(in) WT._____(lbs.)	
Suppliers Name: _____ **Suppliers NPI Number:** _____	Suppliers Address and Telephone Number: _____
Physicians Name: _____ **Physicians NPI Number:** _____	Physicians Address and Telephone Number: _____
HCPCS Code(s)	
Place of Service	

Primary Diagnosis_____ ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity: _____

ICD-10 Diagnosis Code(s)_____

List the Manufacturer's name _____Model #_____

Required: Submit a copy of the quote invoice or manufacturer's price list with prior authorization request.

Equipment Prescribed (All items must contain the specific names of the Device/Accessories /Software and must match SLP Evaluation, and be the least costly alternative for this product category):

DETAILED PRODUCT DESCRITPION	HCPCS CODE

Based on the Speech Language Pathologists report, this equipment has been demonstrated to be useful and effective in the communication needs of the patient? ☐ YES ☐ NO

Expected prognosis with effective use of the device: _____

_____

_____

Patient Name:_____DOB:_____

This request is for: ☐ Purchase ☐ Rental

The Length of Need will be for _____ months (99= lifetime of device (minimum 3 years)

Ordering Physician

I certify that the prescribed mobile device and application ordered are reasonable and necessary to achieve the functional communication goals stated for the patient in the Speech-Language Pathologist's evaluation and plan of care. My order is based on an evaluation that was performed by a licensed Speech-Language Pathologist and includes the patient's physical, language and communication abilities and needs, and who has experience in the use of this device and software or application for speech therapy services., and that I have had a face-to-face evaluation with this member to discuss and review the appropriateness of the device within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Additionally, I certify that I have reviewed a copy of the Speech-Language Pathologist's completed evaluation for the appropriate mobile device and software or application to be used for Augmentative and Alternative Communication therapy, and I agree with the recommendation for this equipment.

Date of face-to-face evaluation _____/_____/_____ (Must have occurred within 180 days prior to the order date)

Physician's Signature_____ Date_____/_____/_____

Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.