

* Example of GA CMN *



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 <u> </u> / <u> </u> / <u> </u> REVISED <u> </u> / <u> </u> / <u> </u>	
Members Name: <u>John Doe</u>	Members Medicaid Number (Do <u>Not</u> List Mother's ID): <u> </u>
Patient DOB <u>01/01/2010</u> Sex <u>M</u> HT. <u>40"</u> (in) WT. <u>50</u> (lbs.)	
Suppliers Name: <u>Prentke Romich Company</u>	Suppliers Address and Telephone Number: <u>1022 Heil Road</u> <u>Wooster, Oh 44691</u> <u>800-123-4457</u>
Suppliers NPI Number: <u>1184602518</u>	
Physicians Name: <u>Dr. John Smith</u>	Physicians Address and Telephone Number: <u>133 Main St</u> <u>Wooster, Oh 44691</u> <u>330-123-4457</u>
Physicians NPI Number: <u>123456789</u>	
HCPCS Code(s) <u>E2510 E2599</u>	
Place of Service <u>12</u>	

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Blank

Primary Diagnosis Autism ICD-10 Diagnosis Code F84.0
 Secondary Diagnoses supporting medical necessity: Mixed Receptive-Expressive Language
 ICD-10 Diagnosis Code(s) F80.2
 List the Manufacturer's name PRC Model # Accent 800

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 DESCRIPTION	HCPCS CODE
<u>Accent 800 dedicated Unity</u>	<u>E2510</u>
<u>84 Location Keyboard</u>	<u>E2599</u>
<u>Additional battery charger</u>	<u>E2599</u>

Based on the Speech Language Pathologist's 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: Please list the medical necessity information here



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Patient Name: John Doe DOB: 01/01/2010

This request is for: Purchase Rental

The Length of Need will be for 99 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 11/10/18 (Must have occurred within 180 days prior to the order date)

Physician's Signature Dr's signature here Date 11/11/18

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.