GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Durable Medical Equipment/Supplies Face-To-Face Encounter Certification

PATIENT NAME:	**D.O.B.** _____/_____/_____ Month Day Year
Medicaid ID:	**Height** _____ **Weight**_____ **(if equipment is being replaced due to growth)**

Face to Face Encounter: I certify that this patient is under my care and that I (MD.DO or DPM), or a physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS), had a face-to-face encounter with this patient on:

Date of Encounter: _____/_____/_____
Month Day Year
(The encounter must occur within six months prior to the order for equipment and/or supplies)

The encounter with this patient was, in whole or in part, for the following medical condition, which is the primary reason the durable medical equipment and/or supplies is necessary:

List the primary medical condition that supports the medical necessity, or the item(s) ordered:

_____

I certify, that based on my findings, the following services are medically necessary:

List all items for which an order will be provided to a supplier of durable medical equipment:

Equipment_____

Supplies_____

Attending Physician _____

NPI _____ Date_____

Also, complete if the clinical professional is anyone other than the attending physician (PA, NP, or CNS):

Name/Credentials_____

NPI _____ Date_____

Please complete this form and provide it to the Durable Medical Equipment

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: _____

_____

_____

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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.