GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

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

PATIENT NAME: John Doe	**D.O.B** 01 / 01 / 2010 Month Day Year
Medicaid ID: Please list ID# here	**Height** 40" **Weight** 50 lbs **(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: 11 / 10 / 2018
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: Autism F84.0 & Mixed receptive-expressive language disorder F80.2

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 Accent 800 E2510

Supplies additional battery charger E2599

Attending Physician Dr. John Smith NPI 123456789
Date 11/11/2018

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

OR

Name/Credentials **SLP name and credentials** NPI
________________ Date 11/10/18

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