Medicaid

Montana Medicaid Certificate of Medical Necessity

Durable Medical Equipment (DME) and Supplies (Rev. October 2014)

Augmentative Communication Device

Section A

Patient Name, Address, Telephone Number, and Date of Birth **Medicaid ID Number**_____	**Physician Name, Address, and Telephone Number** **NPI Number** _____
Residence ☐ Home ☐ Nursing Home ☐ Hospital Rehab Unit ☐ Group Home ☐ Other _____	
Diagnosis	**Estimated Length of Need (Months):_____ 1–99 (99=Lifetime)**
Prognosis for unassisted communication?	
What is the anticipated benefit with a device?	
Date of Last Evaluation by Speech Therapist **Attach evaluation.**	**Therapist's Name**

Section B

1. Has the patient received a trial in the use of this device? ☐ Yes ☐ No
2. Does patient have the physical and mental ability to operate the device? ☐ Yes ☐ No
3. Can the patient or caregiver be responsible for the maintenance of this device? ☐ Yes ☐ No
4. Functional limitations of the patient?
   ☐ Contractures ☐ Paralysis ☐ Ambulation Impaired ☐ Comatose ☐ Muscle Weakness
   ☐ Respiratory Disease ☐ Disoriented ☐ Other (Explain) _____
5. Does this device have environmental controls? ☐ Yes ☐ No
6. Narrative description of **all** items, accessories, sizes, and options, including model numbers to be included in this section. If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document).
   ☐ **Yes**, attachments **are** included. ☐ **No**, attachments **are not** included.

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

Signature and date stamps are not acceptable.

_____ _____

Physician's Signature **Date (mm/dd/yyyy)**