

Ohio Department of Medicaid  
**CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION**  
**SPEECH GENERATING DEVICE (SGD)**  
 **Repair**     **Modification**     **Upgrade**

Name of Provider _____
Provider NPI # _____
Medicaid Legacy # _____

**Instructions: The Certificate of Medical Necessity (CMN) must be used for speech generating devices under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.**

Name of Consumer		Billing Number	
Funding Source of SGD	SGD is necessary to meet the consumer's basic communication needs. <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Birth	
Make, model and Serial # of SGD (include PA # for purchase, if known)	Date Purchased	Are parts requested still under warranty? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Attach copy of warranty.</b>	

**Section A - Repair of SGD**

Type of repair: <input type="checkbox"/> Major <input type="checkbox"/> Minor	Was this SGD purchased through Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Description of required parts needed to complete repair. Include manufacturer price lists.**

Part Code	Name of Part	Reason part needs to be replaced/repared

Describe the nature of the damage to the SGD:

**Section B - SGD Modifications** (attach additional documentation, if needed.)

Consumer's initial condition
Current condition warranting modification
How will modification correct change in condition?

**Section C - SGD Upgrade**

Consumer's initial condition
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**Section C - SGD Upgrade (continued)**

Current condition warranting upgrade

How will upgrade correct change in condition?

**Speech-Language Pathologist (SLP) Attestation and Signature/Date**

Name (*PRINTED*)

***I certify that I am the SLP identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.***

SLP Signature

Date

License #

**Prescriber Attestation and Signature/Date**

Prescriber Name (*PRINTED*)

***I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.***

Prescriber signature (*No stamps*)

Date

Medicaid Provider #