## \* Example of GACMN\*



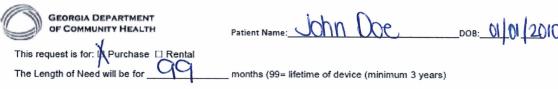
## CERTIFICATION OF MEDICAL NECESSITY FOR SPEECH GENERATING DEVICES AND MOBILE DEVICES USED AS A SPEECH GENERATING DEVICE WITH AAC THERAPY APPLICATION OR SOFTWARE

\*SLP ASSESSEMENT REQUIRED\* Leave this Certification Type/Date: INITIAL Members Medicaid Number (Do Not List Mother's ID): Members Name: ciónn Patient DOB (lbs.) Suppliers NPI Number: Physicians NPI Number: HCPCS Code(s) Place of Service Primary Diagnosis ICD-10 Diagnosis Cod Secondary Diagnoses supporting medical necessity: MIXEO ICD-10 Diagnosis Code(s) List the Manufacturer's name 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 Based on the Speech Language Pathologists report, this equipment has been demonstrated to be useful and effective in the communication needs of the patient?

Page 1 of 2

Revised 1/1/2019

CMN for Speech Generating Devices or Mobile Devices



## 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 Dr'S SiO	nature 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.

Revised 1/1/2019

CMN for Speech Generating Devices and Mobile Devices

Page 2 of 2