eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – AUGMENTATIVE (ALTERNATIVE) COMMUNICATION DEVICE (ACD) AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Beneficiary Name: ______________________________ Medicaid #: ______________________________ Date of Birth: ____/_____/____ Age:____ Sex: ___ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: _________________________	Ordering Physician's Name (First and Last): ____ MS Medicaid ID#: ______________________________ Telephone #: (_____) _______-__________ Ext. ______

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___ 1 – 99 *(99 = Lifetime)*

ANSWERS	**Circle Y for Yes N for No or D for Does not apply**
Y N D	Has a team of licensed, qualified professionals evaluated the beneficiary? If yes, identify professions involved below: ☐ Speech-language pathologist ☐ Licensed psychologist with expertise in administering nonverbal test for intelligence ☐ Physical Therapist ☐ Occupational Therapist ☐ Other: (Record Profession) ____ NOTE: A written copy of the evaluation and recommendation must be submitted with the request for approval. (Refer to coverage criteria for specifications).
Y N D	Is the beneficiary's ability to communicate using speech and/or writing insufficient for communication purposes?
Y N D	Is the beneficiary mentally, emotionally, and physically capable of operating/using an ACD?
Y N D	If a request is for rental, has a trial period of at least 30 days, not to exceed 90 days, to ensure that the beneficiary's needs are met by the proposed system and in the most cost-effective manner been conducted? If yes, record dates of trial period: ______________________________

PHYSICIAN ORDER: ***(Prescription should include specifications for ACD, component accessories, and all necessary therapies and training.)***

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The physician order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C **PHYSICIAN ATTESTATION, SIGNATURE AND DATE**

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed durable medical equipment, orthotics, prosthetics, or medical supplies, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in Section A of this form. I certify that the medical necessity information in Section B is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

______________________________________ ______________________

Signature of Physician Date