



**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\***

Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___	
Members Name: John Doe	Members Medicaid Number (Do <u>Not</u> List Mother's ID): 0123456789
Patient DOB <u>01</u> / <u>01</u> / <u>2010</u> Sex <u>M</u> HT. <u>40</u> (in) WT. <u>50</u> (lbs.)	
Suppliers Name: PRC-Salttillo	Suppliers Address and Telephone Number: 1022 Heyl Rd. Wooster, OH 44691
Suppliers NPI Number: 1184602518	Phone - <u>330-262-1984</u> Fax - <u>330-202-5840</u>
Physicians Name: Dr. John Smith	Physicians Address and Telephone Number: 133 Main Street
Physicians NPI Number: 987654321	Wooster, OH 44691 330-123-4451
HCPCS Code(s)	E2510, E2599
Place of Service	12- Home

Primary Diagnosis Autism ICD-10 Diagnosis Code F84.0  
 Secondary Diagnoses supporting medical necessity: Mixed Receptive-Expressive Language Disorder  
 ICD-10 Diagnosis Code(s) F80.2  
 List the Manufacturer's name PRC-Salttillo Model # Via Pro

**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 DESCRIPTION	HCPCS CODE
ViaPro	E2510
extra battery charger	E2599
60 location keyguard	E2599

Based on the Speech Language Pathologists report, this equipment has been demonstrated to be useful and effective in the communication needs of the patient?  YES  NO

Expected prognosis with effective use of the device: Good.



Patient Name: John Doe DOB: 01/01/10

This request is for:  Purchase  Rental

The Length of Need will be for 99 months (99= lifetime of device (minimum 3 years))

**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 ten (10) 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 02 / 22 / 2026 (Must have occurred within 304 days prior to the order date)

Physician's Signature Dr's Signature here Date 03 / 01 / 2026

**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.**