Ohio Department of Job and Family Services

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION SPEECH GENERATING DEVICES (SGD) RECERTIFICATION

Name of Provider	
Provider NPI #	
Medicaid Legacy #	

Instructions: The Certificate of Medical Necessity (CMN) must be used for all 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

☐ Trial/Rental ☐ Purchase	Were rental dates previously approved? ☐ Yes ☐ No	If "Yes", List Prior Authorization #'s / Authorized Dates	Date of Birth

Rental

Dates of trial period

From to

Describe the outcome of the trial use period.

If long-term rental is required, document why it is necessary as an alternative to a trial use period and/or purchase.

Purchase

Is consumer compliant with SGD use? ☐ Yes ☐ No - Explain:

Is patient continuing to benefit from the device? ☐ Yes ☐ No - Explain:

How is the SGD meeting the needs of the consumer?

Are there factors which prevent the consumer's successful utilization of the SGD?

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 *(No stamps)*	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 #