eQHealth Solutions

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

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Beneficiary Name: Joe Doe

Medicaid #: 123 456 789

Date of Birth: 1 / 1 / 11 Age: 10 Sex: M (M or F)

HT: 75 (inches) WT: 75 (lbs)

Date of last visit: 7/21/2021

Ordering Physician's Name (First and Last):

Dr John Smith

Must be 8 numbers

MS Medicaid ID#: 01234567

Starts with a Zero

Telephone #: (123) 456 - 7890 Ext. _____

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN)

DIAGNOSES	ICD-10-CM
Autism	F84.0
Mixed Receptive Expressive Language	F80.2

Est. Length of Need (# of Months): 99 **1 – 99** *(99 = Lifetime)* → Must be marked!!

Must be answered

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.)***

Must List Specific Device + Accessories. List Speech Therapy & Time

Ex. Accent 800 dedicated unity, 84 Location Keyguard

Speech Therapy 2x week for 20 weeks

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.

Physician Sign + Date

Signature of Physician Date