

Name of provider: \_\_\_\_\_

Provider NPI # \_\_\_\_\_

Medicaid Legacy # \_\_\_\_\_

Ohio Department of Job and Family Services  
**CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION  
SPEECH GENERATING DEVICES (SGD)  
RECERTIFICATION**

**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	
<input type="checkbox"/> Trial/Rental	Were rental dates previously approved?	If "yes", list Prior Authorization #'s	Date of Birth
<input type="checkbox"/> Purchase	<input type="checkbox"/> Yes <input type="checkbox"/> No	Authorized dates	
<b>Rental</b>			
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.			
<b>Purchase</b>			
Is consumer compliant with SGD use? <input type="checkbox"/> Yes <input type="checkbox"/> No—Explain:			
Is patient continuing to benefit from the device? <input type="checkbox"/> Yes <input type="checkbox"/> 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?			
<b>Speech-Language Pathologist (SLP) Attestation and Signature/Date</b>			
Name (Printed)			
<i>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.</i>			
SLP signature (No stamps)	Date	License#	
<b>Prescriber Attestation and Signature/Date</b>			
Prescriber Name (Printed)			
<i>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.</i>			
Prescriber signature (No stamps)	Date	Medicaid Provider #	