

Name of provider: \_\_\_\_\_  
Provider NPI # \_\_\_\_\_  
Medicaid Legacy # \_\_\_\_\_

Ohio Department of Job and Family Services  
**CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION**  
**Speech Generating Device (SGD)**

**Repair**     **Modification**     **Upgrade**

**Instructions: The Certificate of Medical Necessity (CMN) must be used for 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:	
Funding source of SGD	<input type="checkbox"/> Y <input type="checkbox"/> N SGD is necessary to meet the consumer's basic communication needs	Date of Birth	
Make, model and Serial # of SGD (include PA # for purchase, if known)	Date purchased	<input type="checkbox"/> Yes <input type="checkbox"/> No Are parts requested still under warranty? <b>Attach copy of warranty.</b>	
<b>Section A—Repair of SGD</b>			
Type of repair: <input type="checkbox"/> Major <input type="checkbox"/> Minor	<input type="checkbox"/> Yes <input type="checkbox"/> No Was this SGD purchased through Medicaid?		
<b>Description of required parts needed to complete repair. Include manufacturer price lists.</b>			
<b>Part Code</b>	<b>Name of Part</b>	<b>Reason part needs to be replaced/repared</b>	
Describe the nature of the damage to the SGD:			
<b>Section B—SGD Modifications</b> (attach additional documentation, if needed.)			
Consumer's initial condition			
Current condition warranting modification			
How will modification correct change in condition?			
<b>Section C—SGD Upgrade</b>			
Consumer's initial condition			

**Section C—SGD Upgrade (continued)**

Current condition warranting upgrade

How will upgrade correct change in condition?

**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:

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 #: