

# MEDICAID

## MONTANA MEDICAID CERTIFICATE OF MEDICAL NECESSITY DURABLE MEDICAL EQUIPMENT AND SUPPLIES (Rev., May 2007)

### AUGMENTATIVE COMMUNICATION DEVICE EST. LENGTH OF NEED (# OF MONTHS): \_\_\_\_\_ 1-99 (99=LIFETIME)

#### SECTION A

PATIENT NAME, ADDRESS, TELEPHONE NUMBER, DATE OF BIRTH

PHYSICIAN NAME, ADDRESS, TELEPHONE NUMBER

MEDICAID I.D. NUMBER:

NPI NUMBER:

RESIDENCE: (CIRCLE ONE) Home, Nursing Home, Hospital Rehab Unit, Group Home, Other: \_\_\_\_\_

DIAGNOSIS:

PROGNOSIS FOR UNASSISTED COMMUNICATION:

WHAT IS THE ANTICIPATED BENEFIT WITH A DEVICE:

DATE OF LAST EVALUATION BY SPEECH THERAPIST:  
(Attach evaluation)

THERAPIST NAME:

DATE OF LAST EVALUATION BY PHYSICIAN:

PHYSICIANS NAME:

#### SECTION B

1. Has the patient received a trial in the use of this device: Y / N

2. Does patient have the physical and mental ability to operate the device: Y / N

3. Can the patient or care-giver be responsible for the maintenance of this device: Y / N

4. Functional limitations of the patient: (Please circle)

Contractures    Paralysis    Ambulation Impaired    Comatose    Muscle Weakness    Respiratory Disease

Disoriented    Other (Please explain):

5. Does this device have environmental controls: Y / N

6. Narrative description of **ALL** items, accessories, sizes and options, etc., to included model numbers in this section: (If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document).

Y / N    ADDITIONAL ATTACHMENTS ARE INCLUDED

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE

DATE / / (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)