CERTIFICATE OF MEDICAL NECESSITY

Speech Generating Device (SGD)
SECTION A Certification Type/Date: INITIAL / /

SECTION A	**Certification Type/Date: INITIAL / /**	**RECERTIFICATION / /**
PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID NUMBER ( ) - MEDICARE ID NUMBER:		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
PLACE OF SERVICE NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE	PATIENT DOB / / SEX: FEMALE ☐ MALE ☐ HEIGHT IN INCHES: WEIGHT IN LBS. PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER ( ) - UPIN

SECTION B Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS) 1-99 (99=LIFETIME) **DIAGNOSIS CODES (ICD-9):**

ITEM ADDRESSED	**ANSWERS**	**ANSWER QUESTIONS 1-6 FOR SGD, OPTIONS/ACCESSORIES; 7 FOR repairs, 8 for UPGRADE/REPLACEMENT.** **(Y** for **Yes, N** for **No, D** for **Does not apply** (unless otherwise noted)
SGD and <u>All Accessories</u>	**Y☐ N☐ D☐**	1. Has the patient had a formal evaluation of cognitive and language ability by a SLP with no financial connection to supplier and a copy of the evaluation submitted to the treating physician?
	Y☐ N☐ D☐	2. Does the patient have a medical condition resulting in a severe expressive speech disability?
	Y☐ N☐ D☐	3. Can the patient's speaking needs be met using natural communication methods?
	Y☐ N☐ D☐	4. Have other forms of treatment been considered and ruled out?
	Y☐ N☐ D☐	5. Will the patient's speech disability benefit from the device?
Accessories	**Y☐ N☐ D☐**	6. Has the medical necessity for each accessory been documented in the formal evaluation?
Repairs	**Y☐ N☐ D☐**	7. Does the patient have continued medical need for the device/accessory for which the repairs are requested?
Upgrade/Replacement	**Y☐ N☐ D☐**	8. Does the upgrade/replacement provide enhanced features or other improvements?

NAME OF PERSON ANSWERING SECTION B QUESTION, IF OTHER THAN PHYSICIAN :
NAME: TITLE: EMPLOYER:

SECTION C Narrative Description of Equipment and Cost

(1) <u>Narrative</u> description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for <u>each</u> item, accessory, and option. (*See instruction on back*.) If additional space is needed, list SGD and most costly options/accessories on this page and continue on back.

☐ CHECK HERE IF ADDITIONAL OPTONS/ACCESSORIES ARE LISTED ON BACK.

SECTION D Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been review and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE.)

SECTION A:	**(May be completed by the supplier.)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 32, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate the patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed and the CMN signed (In Section D) by the ordering physician.)**
ESTIMATED LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	. In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, selecting "Y" for yes, "Y" for no, and "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., SLP) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier.)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician.)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C, and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.