Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: SPEECH-GENERATING DEVICES

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber	Provider
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
	Telephone number	

Provider Attestation

☐ I acknowledge that payment will not be made for the purchase of a SGD until the individual has used it for at least four weeks.

Evaluation by a Speech-Language Pathologist

☐ A copy of the written report is attached.

Certification [This section may be transcribed by the provider.]

Additional sheets may be attached.

Diagnosis code(s)	Date of evaluation
SGD specifications and rationale	
Cognitive and physical ability of the individual to use the specified SGD	
Why SGD equipment currently in the individual's possession does not meet the individual's needs	
Medical necessity of requested accessory or add-on equipment, supplies, or features	
Necessity or functional benefit of requested upgrade, modification, or replacement	

Prescriber Attestation

I hereby attest that the certification information above is true, correct, and complete.	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.