**CERTIFICATE OF MEDICAL NECESSITY**

**REQUEST FOR DURABLE MEDICAL EQUIPMENT (DME)**

**Name:** XXXXX XXXXX
**Parents:** Parent Names
**Address:** XXX
XXXX, OK XXXXX
**Telephone:** xxx-xxx-xxxx
**Date of Letter:** XX-XX-XXXX
**Date of Birth:** XX-XX-XXXX
**Age:** X years
**Insurance or Medicaid # or both if applicable : Policy #**XXXXXXXXXX **Group** #: XXXXXXXXXX
**Diagnosis:** ICD-9 Code: *Name of Disability (e.g.,* Other developmental speech disorder) (XXX.XX)
**Physician:** Dr. XXXXXXX

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**XXXXX'S CHARACTERISTICS:**

XXXX XXXX is a X yr old female/male with an diagnosis of : XXXX. XXXX is DESCRIBE CURRENT COMMUNICATION ABILITIES AND DEFICITS. XXXXX's parents and are interested in determining if XXXXX would be able to communicate using an Augmentative Communication Device (AAC)/Speech Generating Device (SGD).

**CONCERNS:**

XXXXX is unable to communicate his wants and needs with others. He is unable to communicate about health/medical needs with his family, caregivers, therapists, nurses, and doctors. He cannot call for help in an emergency situation, and cannot tell his name, address, or parents' names to emergency personnel. XXXXX's current lack of an easily understood communication method jeopardizes his health and safety.

**NEEDS:**

XXXXX needs durable medical equipment (DME) for communication. An augmentative communication device will enable him to tell his wants and needs, as well as share health and safety information. This device will speak when XXXXX touches various pictures/messages on its screen so that others may hear and understand him. XXXXX borrowed the recommended device for a two-week trial period and demonstrated the desire and ability to use it for functional communication. A complete list of necessary equipment is listed below, with justification for each item provided in *italics.*

NAME OF DEVICE ……..$XXX.00

*The NAME OF DEVICE is the preferred communication device for XXXXX at this time. It is lightweight and portable so that he may have it with him at all times for safety reasons. XXXXX demonstrated the ability to use this device to achieve functional communication.*

ACCESSORIES …….$XXX.00

*LIST ALL NEEDED ACCESSORIES SUCH AS CARRY CASE, STRAP, EXTRA BATTERY, ADDITIONAL PICTURE SYMBOLS, ETC…*

Thank you for considering this request for DME for XXXXX Long. Please call ADD YOUR CONTACT PHONE NUMBER if additional information is needed.

Respectfully,

_____

XXXXXXX, M.S., CCC-SLP Date
ASHA # XXXXXXXXXXX
OK State SLP Licensure #XXXXXXXx

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Dr. XXXXXXXXXXX Date
CHILD NAME'S primary care physician
UPIN #: XXXXXX
NPI #: XXXXXXXXXXx
State Licensure #: XXXXXXXXx
Medicaid Provider #: XXXXXXXXXXXx