Idaho Medicaid SGD Supplemental Form

Please complete entire form and submit with DME Prior Authorization Form to (877) 314-8782

Date of Evaluation:

Medicaid Participant Information

Last Name:	First Name:	Medicaid ID:
Speech-Language Diagnosis:		
Date of Onset:		

Speech-Language Pathologist Information

Provider Name:	Phone:

Summary of Current Skills

Summarize Development and Speech and Language Skills: (Please, include inventory of communication skills and sensory function.)	

Previous AAC System:	Length of Use:

☐ N/A ☐ Aided ☐ Unaided ☐ Low-Tech ☐ High-Tech

Comments:

Current AAC System:	Length of Use:

☐ N/A ☐ Aided ☐ Unaided ☐ Low-Tech ☐ High-Tech

Document Repair History:

Comments:

Why are you requesting a SGD?	
What features are needed or requested by this client and their caregivers?	
What are the anticipated communication needs to warrant a SGD?	

Trial Information

Device Trialed:

Date Trial Started: Duration of Trial:

Direct Select: ☐ Eyes ☐ Touch ☐ Other:

Scanning: ☐ One Switch ☐ Two Switch ☐ Auditory ☐ Visual

Summary:

Device Trialed:

Date Trial Started: Duration of Trial:

Direct Select: ☐ Eyes ☐ Touch ☐ Other:

Scanning: ☐ One Switch ☐ Two Switch ☐ Auditory ☐ Visual

Summary:

Device Trialed:

Date Trial Started: Duration of Trial:

Direct Select: ☐ Eyes ☐ Touch ☐ Other:

Scanning: ☐ One Switch ☐ Two Switch ☐ Auditory ☐ Visual

Summary:

SGD Recommendation

SGD Recommended:

Model Name: Model Number:

Software Recommended:

Accessories/Mounting:

Why is this combination of hardware and software the best choice for the client?	

Support Team

Please, list support team names and numbers (i.e. special education teacher, physical therapist, occupational therapist, school/private speech-language pathologist, habilitative interventionist, etc.).

Name of Team Member/Role	Phone Number

Who is responsible for programming, updating and maintenance of the device?	
How has the client's IEP team, caregiver, or other communication partners been included in this evaluation process?	

Additional Required Documentation

☐ Current speech/language reports including plane of care.

☐ If applicable: Current Individualized Education Program (IEP).

☐ If applicable: Letters documenting necessity.

Acknowledgement

By signing below, I agree that I am not an employee of, or have a financial relationship, with any assisted technology/speech generating device manufacturer. I agree to the information and recommendations in this report.

Speech-Language Pathologist Signature Date

Physician Signature Date

The status of a prior authorization request may be checked online at the www.idmedicaid.com under "Authorization Status", using your NPI, or by contacting Molina at (866) 686-4272.

Reset Form